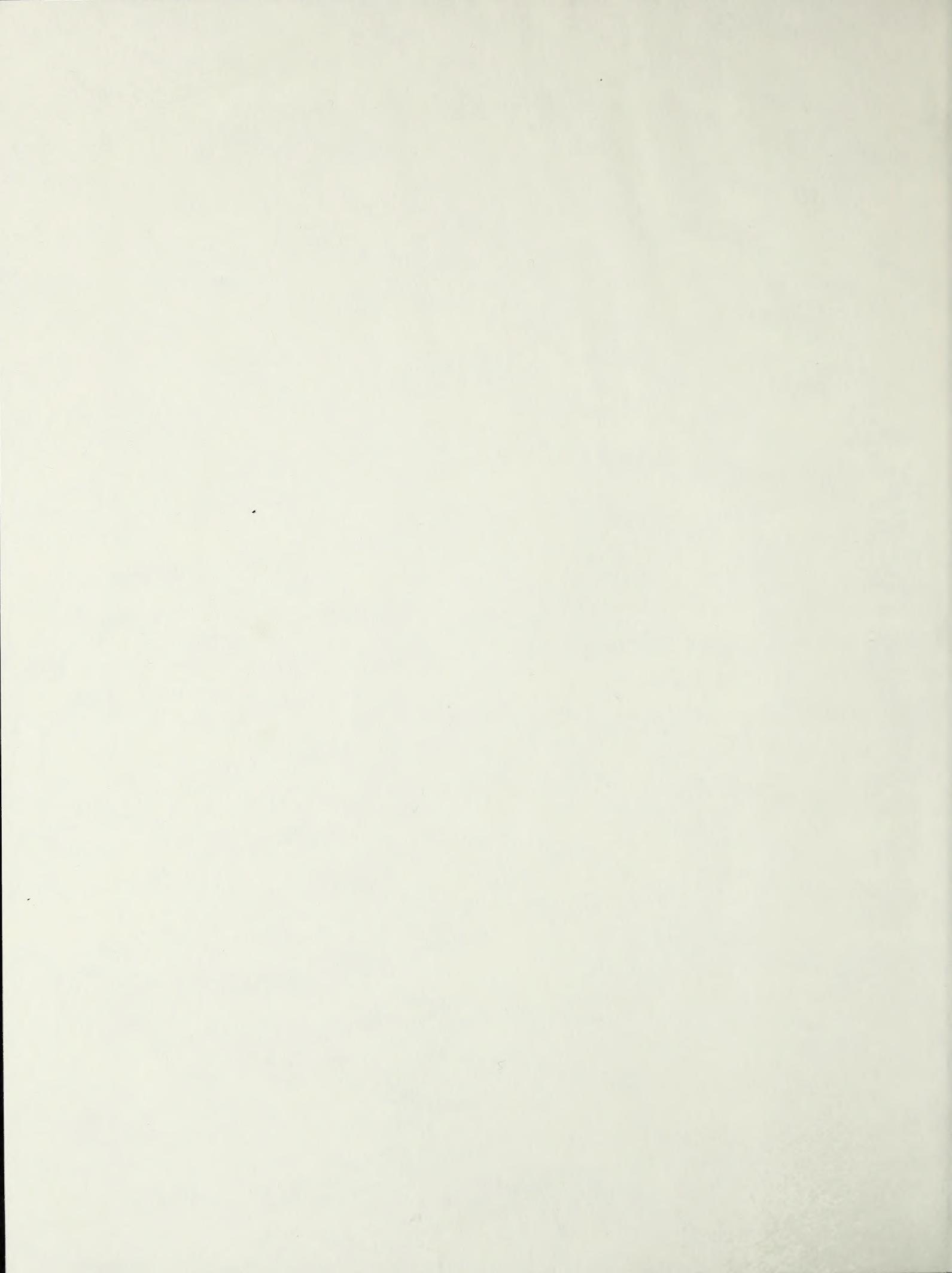




Digitized by the Internet Archive
in 2013

<http://archive.org/details/earlyrehabilitat00mann>



HV1593
. PG47

RECEIVED

NOV 29 1966

PILOT STUDY

D. P. S.

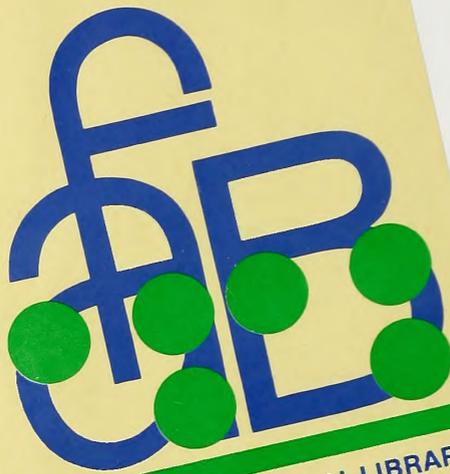
EARLY REHABILITATION SERVICES
FOR THE BLIND

M. Anne McGuire
Project Director
Mrs. Janet Sillen
Assistant Project Director

THE JEWISH GUILD FOR THE BLIND
1880 Broadway
N.Y. N.Y. 10023

June 1966

This investigation was supported, in part, by a planning grant, number RD - 1969 - S - 65, from the Vocational Rehabilitation Administration, Department of Health, Education and Welfare, Washington, D.C. 20201



M.C. MIGEL MEMORIAL LIBRARY
American Foundation for the Blind
15 West 16th Street, New York, New York
10011

c12

TABLE OF CONTENTS

	<u>Page</u>
FOREWORD	i
ACKNOWLEDGEMENTS	ii
COMMITTEES, ADVISORS AND INTERVIEWERS	iii
I. INTRODUCTION	1
II. METHODOLOGY	4
III. CHARACTERISTICS OF THE BLIND PERSONS INTERVIEWED	9
IV. FINDINGS AND IMPLICATIONS RELATED TO EARLY REHABILITATION SERVICES AFTER THE ONSET OF BLINDNESS	11
A. How Extensive is the Gap Between Onset of Serious Eye Condition and the Offering of Rehabilitation Services?	12
B. What are the Major Reasons Why Many Visually Handicapped Persons do Not Seek Services Promptly or Utilize them When They are Offered?	15
C. Social Stigma Attached to Blindness - The Most Serious Deterrent?	17
D. What is the Effect of Gradual Progression in the Loss of Sight?	31
E. False Hope. A Deterrent in Rehabilitation?	35
F. How Much is Known About Specialized Agencies and Their Services?	40
G. How are Specialized Agencies Perceived - Their Image - Attitudes Toward - Experiences With?	51
H. Failure to Communicate - Why?	61
I. How are Rehabilitation Goals Influenced by Medical Practices?	64
V. SUMMARY OF CONCLUSIONS	74
VI. RECOMMENDATIONS	81
TABLES	82
APPENDIX	84
BIBLIOGRAPHY	91

FOREWORD

Over three decades, we have heard a clear and distinct voice from The Guild staff describing the mutually satisfying results in the rehabilitation of the blind person who seeks service before he settles into an accommodated existence of life with a visual loss. Why it took others much longer to accept help, and the extra problems they presented, has been a continuing challenge. It was this recognition of the importance of early rehabilitation that led The Guild to discuss with Dr. Salvatore Di Michael, Regional Representative of the Vocational Rehabilitation Administration, the pressing need to study the problem of the time gap between the onset of blindness and the utilization of available services. With his continuing encouragement, invaluable guidance and inspiration, a Vocational Rehabilitation Administration planning grant was requested and approved. Grateful acknowledgement is also made to The Almaire R. and Herbert A. Klugman Research Fund whose generous contribution made it possible for The Guild to match the support of the Vocational Rehabilitation Administration.

The active and generous cooperation of the New York State Commission for the Blind, The Industrial Home for the Blind, and the New York Association for the Blind has made it possible for The Guild to conduct a pilot study during the year 1965-66. The findings presented in this report give us invaluable clues concerning the relative significance of many of the known reasons for the delay in service. They serve also to point up the most important of those areas in which further study is urgently needed and those which realistically can be approached immediately. We are convinced that a concerted community assault by professional personnel in all fields which bring them into contact with visually handicapped persons will be needed if unnecessary delays are to be avoided in future years. It is our further belief that the pilot study has pointed the way for the cooperative community planning which will have to be done if we are to achieve the objective of early rehabilitation services for all who need them.

The fervor and flavor of the results of this study are due to the leadership of M. Anne McGuire, the Project Director, whose special qualifications for developing and organizing this study insured its great value. Our thanks go also to Mrs. Janet Sillen who served so ably as Assistant Director.

Mrs. Sidney E. Pollack
Administrative Director
The Jewish Guild for the Blind

ACKNOWLEDGEMENTS

Without the lively interest and unstinting energy which Mrs. Sidney E. Pollack, Administrative Director of The Jewish Guild for the Blind, devotes to the charting of new paths and the opening up of new vistas of service for visually handicapped persons, this pilot study would not have been possible. Once undertaken, with a planning grant from the Vocational Rehabilitation Administration, her leadership and encouragement, together with the unfailing help of innumerable members of her staff, have earned the warm appreciation of the pilot study staff.

Gratitude goes to the members of the Advisory Committee for their wise guidance while the Study was in process and for their continuing interest in the utilization of the findings to make rehabilitation services available to blind persons as early as feasible. In particular, the gracious assistance of Dr. Peter J. Salmon, Mr. Wesley Sprague, and Mr. Oscar Friedensohn in making key members of their staff available for advice and counsel during the period of the study is greatly appreciated. The contribution of William Generette, Elizabeth Maloney, Virginia McDonough, Mrs. Evelyn Prince, David Soyer and Mrs. Frances Dover was of inestimable value at every stage in the development of the study. Warm appreciation also goes to the staff of the agencies and graduate student interviewers, who, with patience and skill conducted the field interviews. We regret that they are too numerous to mention by name.

The prompt and efficient cooperation of the New York State Commission for the Blind facilitated the selection of the sample of blind respondents; other important statistical and medical information was also graciously supplied when requested. The willingness of the blind respondents to participate in a research study in order that other visually handicapped persons might be benefitted was noteworthy and their generous cooperation in lengthy interviews was an indispensable component of the study.

Professor Samuel Finestone gave support and encouragement to the project from its inception. His expertise in research was generously shared and students in his, and Dr. Shirley Jenkins', Columbia University classes carried the major burden of the interviews. We are very grateful to them and to Dr. Ruth Kantrow and Dr. Celia Deschin whose Adelphi University's research classes also accepted responsibility for interviewing. These class projects involved an unusual amount of administrative planning and detail which was handled responsibly and with great patience.

The doctors who gave of their valuable time for interviews focusing on rehabilitation matters have also made an essential contribution to a better understanding of the reasons why a gap often occurs between the onset of blindness and rehabilitation services. A special word of thanks goes to Dr. George E. Wise and the Sub-committee on Rehabilitation of the Medical Advisory Committee of the New York State Commission for the Blind, for their help in analyzing the responses of the doctors and for their suggestions for future planning.

The members of the Committee of Directors of Hospital Social Service Departments were also especially helpful in their provocative discussion, analysis of the problem and constructive suggestions.

To Mrs. Syril Goldstein, sincere thanks are expressed for her unfailing dedication to handling, as the full-time member of the pilot study staff, all office matters and materials relating to the project, responsibly and efficiently. Without her able assistance the project could not have been completed within the limited time available.

ADMINISTRATIVE

Without the lively interest and assistance of the various administrative divisions of the State, it is not possible to carry out the various projects of the State. It is necessary to have the cooperation of all the departments and agencies of the State, and to have them work together in a harmonious and efficient manner.

It is the policy of the State to have the various departments and agencies work together in a harmonious and efficient manner. It is necessary to have the cooperation of all the departments and agencies of the State, and to have them work together in a harmonious and efficient manner.

The various departments and agencies of the State should work together in a harmonious and efficient manner. It is necessary to have the cooperation of all the departments and agencies of the State, and to have them work together in a harmonious and efficient manner.

It is the policy of the State to have the various departments and agencies work together in a harmonious and efficient manner. It is necessary to have the cooperation of all the departments and agencies of the State, and to have them work together in a harmonious and efficient manner.

The various departments and agencies of the State should work together in a harmonious and efficient manner. It is necessary to have the cooperation of all the departments and agencies of the State, and to have them work together in a harmonious and efficient manner.

It is the policy of the State to have the various departments and agencies work together in a harmonious and efficient manner. It is necessary to have the cooperation of all the departments and agencies of the State, and to have them work together in a harmonious and efficient manner.

The various departments and agencies of the State should work together in a harmonious and efficient manner. It is necessary to have the cooperation of all the departments and agencies of the State, and to have them work together in a harmonious and efficient manner.

COMMITTEES, ADVISORS AND INTERVIEWERS

ADVISORY COMMITTEE

Mrs. Sidney E. Pollack, Chairman, Administrative Director, The Jewish Guild for the Blind

Mrs. Celia Benney, Associate Director, Altro Health and Rehabilitation Service

Oscar Friedensohn, Director, New York State Commission for the Blind

George James, M.D., Dean of Medical School, Mt. Sinai Hospital

Dr. Hope Leichter, Associate Professor, Rutgers University

Harold Roberts, Director of Program Planning, American Foundation for the Blind

Peter Salmon, LLB, Executive Director, Industrial Home for the Blind

Mignon Sauber, Director of Research, Community Council of Greater New York

Wesley Sprague, Executive Director, New York Association for the Blind

Florence Stattel, Regional Rehabilitation Coordinator, N.Y.C. Dept. of Health

George E. Wise, M.D., Chairman, Medical Advisory Committee, N.Y. State Commission for the Blind

SPECIALIZED AGENCIES COMMITTEE

Mrs. Frances Dover, Assistant Administrative Director, The Jewish Guild for the Blind

William Generette, Casework Consultant, New York Association for the Blind

Elizabeth Maloney, Dir. of Educ. and Soc. Services, Industrial Home for the Blind

Virginia McDonough, Assistant Director, N.Y. State Commission for the Blind

Mrs. Evelyn Prince, Community Service Consultant, N.Y. State Comm. for the Blind

David Soyer, Director of Social Service, The Jewish Guild for the Blind

PHYSICIAN COMMITTEE*

George E. Wise, M.D., Chairman, Medical Advisory Committee, N.Y. State Commission for the Blind, Professor of Ophthalmology, N.Y.U. Medical School

I. Jay Brightman, M.D., Assistant Commissioner, Chronic Disease Service, N.Y. State Department of Health

Eleanor E. Faye, M.D., Medical Dir., Low Vision Lens Service, N.Y. Assoc. for the Blind

Adolph Posner, M.D., Chief, Glaucoma Clinic #1, Manhattan Eye and Ear Hospital

* Members of the Rehabilitation Committee of the Medical Advisory Committee of the New York State Commission for the Blind

COMMITTEES, ADVISORS AND INTERVIEWERS (Cont.)

MEDICAL SOCIAL WORK COMMITTEE - DIRECTORS OF SOCIAL SERVICE DEPARTMENTS

Mrs. Mae Gloster, Kings County Hospital Center
Hazel M. Halloran*, St. Vincent's Hospital and Medical Center
Virginia C. Irvine*, Bellevue Hospital Center
Margaret Lehman, New York Eye and Ear Infirmary
Marguerite Lohrer, Manhattan Eye, Ear and Throat Hospital
Helen Lokshin, Elmhurst Hospital Center
Elizabeth R. Prichard, Presbyterian Hospital in the City of New York
Mrs. Lillian M. Richards*, New York City Department of Hospitals
Marian E. Russell, Montefiore Hospital and Medical Center
Doris Siegel*, Mt. Sinai Hospital of New York
Mrs. Hazel S. Taylor, New York City Department of Health
George James, M.D., Ex-officio*, Dean of Medical School, Mt. Sinai Hospital

GRADUATE SCHOOL STUDENT SUPERVISORS** - (Research Professors)

Professor Samuel Finestone, Asst. Dean, Columbia University, School of Social Work
Dr. Shirley Jenkins, Asst. Professor, Columbia University, School of Social Work
Dr. Ruth Kantrow, Asst. Professor, Adelphi University, School of Social Work
Dr. Celia Deschin, Assoc. Professor, Adelphi University, School of Social Work

INTERVIEWERS

New York Association for the Blind

William Generette, Casework Consultant
Joseph Kurstein, Vocational Counselor
Martha Lomax, Research Assistant

The Jewish Guild for the Blind

Mrs. Margaret Watt, Sr. Caseworker
Barbara Ryan, Vocational Counselor
Sandra Berkowitz, Case Aide

The Industrial Home for the Blind

Mrs. Edith Patt, Social Worker
John E. Haffly, Research Asst.

Schools of Social Work

Adelphi - 13 students
Columbia - 44 students

Pilot Study Staff

Mrs. Janet Sillen, Assistant
Project Director

* Unable to attend meeting

** Class project for 44 Columbia University and 13 Adelphi University second year students in research classes.

RESEARCH REPORT NO. 1 - UNIVERSITY OF CALIFORNIA, BERKELEY

Dr. J. H. ...

... ..

... ..

... ..

... ..

... ..

... ..

... ..

... ..

... ..

... ..

... ..

UNIVERSITY OF CALIFORNIA, BERKELEY

... ..

...

... ..

... ..

... ..

UNIVERSITY

The

The

... ..

... ..

... ..

... ..

... ..

... ..

... ..

... ..

... ..

... ..

CHAPTER I.

INTRODUCTION

Severe visual loss brings with it many needs and problems based on the degree and nature of the loss and the age, temperament, interests and other characteristics of the individual. There is general agreement among those who understand the use of rehabilitation services in the broadest sense* that every visually impaired individual can benefit from a program of rehabilitation geared to the person and his needs. Often the only source through which such services can be made available is through the specialized agencies** serving the blind and visually handicapped. The critical handicapping effect of the loss of vision on the person and his family, places great responsibility on the specialized agencies to make knowledge available about services and also to attempt to engage the visually impaired person in the use of such rehabilitative services.

Experience by agencies over many years has strongly indicated that the earlier professional services are utilized after visual loss becomes serious, the greater the potential for effective readjustment in many areas of living, i.e. retraining, job placement, mobility and orientation, self and home care, family and community relationships and in greater emotional comfort with oneself and others. Many agencies serving blind persons have become increasingly aware of the time lag between onset of blindness and the systematic application of rehabilitation services and consider this lag as an important deterrent to early and effective rehabilitation. This pilot project was therefore designed to study the extent of the time lag, reasons for the lag and plans that could be developed to reduce the lag to a minimum, using a limited geographic area (N.Y.C.) and a limited number of cases.

While experience in serving blind and visually handicapped persons over many decades has provided clues concerning some of the reasons for the lag, no planned study or analysis is known to exist on this question. This project was interested in examining the relative degree of importance of the various reasons, the characteristics of the legally blind persons who might be effected, and the degree of interrelatedness of the factors which might have an influence on the time lag. It was felt that these areas needed to be studied in depth.

Since the areas to be studied are extremely complex, it was recognized that long and painstaking future research would be required. The emphasis of the pilot study has been to assemble broad preliminary data and information from a number of sources which included a selected group of blind persons, their relatives and friends, ophthalmologists, general medical practitioners, key medical social workers in hospitals, and key professional staff both in agencies for the blind and in other community social and health agencies. On the basis of preliminary findings, developed during the exploratory and planning period, it is anticipated that it will be possible at a future date to research in depth in a more selective

* Rehabilitation services as referred to in this study include major and minor services offered to persons in relation to their blindness; vocational rehabilitation; training in self-care and home-care; orientation; mobility; low vision optical aids; personal counselling; casework; library services; reader services; braille; social and recreational activity; informational assistance (voting; income tax; etc.)

** Specialized agencies include those voluntary and public agencies offering specialized services for the blind.

CHAPTER I
INTRODUCTION

The first part of the book is devoted to a general survey of the history and development of the law and the legal system. It is a study of the law as it has developed over the centuries, and of the various factors which have influenced its growth. The author discusses the influence of religion, philosophy, and politics on the law, and the role of the courts in the development of the legal system. He also examines the different legal systems of the world, and the ways in which they have been influenced by each other.

The second part of the book is devoted to a study of the law of the individual. It is a study of the rights and duties of the individual, and of the ways in which these rights and duties are protected by the law. The author discusses the law of contract, the law of tort, and the law of property. He also examines the law of the family, and the law of the individual in relation to the state.

The third part of the book is devoted to a study of the law of the state. It is a study of the powers and duties of the state, and of the ways in which these powers and duties are exercised. The author discusses the law of the state in relation to the individual, and the law of the state in relation to other states. He also examines the law of the state in relation to the international community.

The fourth part of the book is devoted to a study of the law of the future. It is a study of the ways in which the law is likely to develop in the future, and of the factors which will influence this development. The author discusses the influence of science, technology, and social change on the law, and the ways in which the law must adapt to these changes. He also examines the role of the courts in the future, and the ways in which the legal system must be reformed to meet the needs of the future.

The book is a study of the law as it has developed over the centuries, and of the ways in which it is likely to develop in the future. It is a study of the law as it is, and of the law as it should be. It is a study of the law as it is, and of the law as it should be. It is a study of the law as it is, and of the law as it should be.

and meaningful way, those factors which are found to be of greatest significance, in achieving early rehabilitation services for those who are in need of them.

The prime source of information about the seeking and utilization of rehabilitation services was considered to be the legally blind person himself, and therefore, discussion with a selected group of blind persons about his feelings and experiences constituted the main focus of the pilot study period. Recognizing the significance of the influence of family members and friends and the vital importance of the early influence of the eye doctor, discussions were also held with a selected group of these persons. It was recognized that the validity of the findings would be directly related to the quality of these discussions. A decision was made therefore to use the interviewing skills of staff employed in the three multi-function service agencies for the blind in New York City. To this interviewing staff was added second year students in research classes at the Columbia University and Adelphi Schools of Social Work.

During the planning period it was considered desirable to select for interviews a group of blind persons for whom it could be reasonably concluded that there had been a gap between onset of blindness and offer of rehabilitation service. The New York State Commission for the Blind assisted by asking those recently registered legally blind persons who according to their records were not known to be receiving service from a specialized agency for the blind, to participate in the confidential research study. It was recognized that this group did not provide a representative sample of the blind population in New York City but this was not considered to be necessary because the pilot study period was primarily exploratory and therefore could provide sufficient preliminary data for further research.

Agencies for the blind have clear awareness that they are not reaching all segments of the population which can utilize their services. At the same time, the specialized agencies are also cognizant that not every blind person is in need of all of the agency's services. It is rather the conviction of many agencies, in line with current psychological thinking, that blind people should have every opportunity for independent living and should retain all possible ties with the sighted community. At the same time, the blind person should also have the opportunity to use those agency services which will help him gain and maintain this independent way of life. In addition, he should have all needed assistance in conserving and making the best possible use of any residual sight he may have.*

The problem of time lag is of primary concern to all of the specialized agencies for the blind as well as to many other agencies and professional groups serving handicapped people. An eleven member Advisory Committee was selected, composed of professionally recognized leaders in the field of services for the blind and allied fields. This Committee, individually and as a group has given valuable leadership in the preliminary study and it is anticipated they will also ultimately be involved in further research and resulting programs put into effect based on findings.

Since it is hoped that this study and any resultant research will lead to improved practice, it was considered important that the advice of selected key staff mem-

* 12% of the total population of blind persons are totally blind and 11.8% have light perception only as reported by the National Society for the Prevention of Blindness based on Model Reporting Area Estimates in ten states in 1963.

bers currently involved in policy development and/or supervision of agency service programs be engaged in setting up the Pilot Study plan. The executives of The Industrial Home for the Blind, The New York Association for the Blind, and The Guild not only served on the Advisory Committee but also made key staff members available to serve on a Specialized Agencies Committee. This Committee brought to bear long years of experience and sound judgement in initiating the original plans and evaluating developments on a continuing basis.

Thirteen doctors, of whom nine are ophthalmologists, agreed to discuss with pilot study interviewers not only rehabilitation questions relating to the blind patient included in the sample, but also their own general rehabilitation philosophy and practices in relation to visually handicapped persons. Medical Social Workers also have a very influential role in connection with the early rehabilitation of visually handicapped persons. Twelve Directors of Hospital Social Service Departments agreed to serve on a Committee, as did four members of the Medical Advisory Committee of the New York State Commission for the Blind. In conference sessions, the community involvement in the problem of the gap was underscored by members of both of these Committees and the need for community action at many levels was clearly indicated.

The findings of the pilot study are, as indicated above, based on interviews and discussions with carefully chosen but numerically limited groups of persons. These persons were not selected as a statistically representative sample of the total population of the groups they represented. The findings of this exploratory study should therefore be validated by further research and the conclusions viewed in terms of trends, directions and new or clarified hypotheses, rather than as definitive findings.

Since any solution to the problem of delay in service will involve many professional persons in many different fields, it was considered desirable to engage the interest of all of the above representative groups as well as their help during the pilot study period. Their interest was encouraging and stimulating; their help was invaluable.

CHAPTER II.

METHODOLOGY

I. Type of Study

The present Pilot Study, as explained in the Foreword, is based on a Planning Grant which was defined as, "support of a project of modest size for the purpose of determining the feasibility or the specific form of a full scale research or demonstration." The Pilot Study is therefore exploratory and non-validating in nature. It is concerned with determining the most important and most feasible of the desirable areas of research regarding early rehabilitation of the visually handicapped. Qualitative rather than quantitative research techniques have been employed. The findings, likewise, have been presented largely in terms of concepts rather than factual findings. An attempt has been made to include all significant concepts emerging from the depth interviews, regardless of the level of frequency on which they occurred.

II. Preliminary Planning

As the first step in the planning of the Pilot Study, conferences were held with a number of social work and research executives in specialized agencies for the blind. These conferences explored the problems related to the time gap between the onset of blindness and the seeking or acceptance of services and proved invaluable in the development of the hypotheses for the research phase of the study.

III. Sample Selection

The sample for the Pilot Study was drawn from two categories of legally blind persons in the registry of the New York State Commission for the Blind: -

- 1) those persons reported by ophthalmologists as legally blind to the New York State Commission for the Blind about whom the Commission had no indication that they were previously known to specialized agencies* for the blind in New York City, and
- 2) those persons, likewise reported by ophthalmologists as legally blind to the New York State Commission, who had specifically indicated that they desire no agency services.

The New York State Commission normally makes a referral to a specialized agency of each legally blind person reported to them by ophthalmologists, unless there is a specific request that no referral be made. The names used were selected chronologically beginning with the most recent (September 1965) New York City registrations and referrals and extending back for a period of approximately 26 months. A total of 532 names of legally blind persons had been referred to these four agencies during this period. 97 persons had requested that no referral be made to an agency.

For use in the Pilot Study the referred cases were screened by the respective agencies** to determine their:

* Brooklyn Bureau of Social Service; The Industrial Home for the Blind; The Jewish Guild for the Blind; The New York Association for the Blind

** See Appendix I, Page 84, for complete statistical data on screening procedures

- 1) Service Status, that is, whether these persons:
 - a) were currently active Service cases
 - b) had rejected the specific agency's offer of service
 - c) had not responded to the agency's offer of service
 - d) had been in previous service but not currently
 - e) were in contact with the agency, but for whom no service status had been determined (pending reception)

- 2) Availability for Inclusion in the Sample, that is whether these persons:
 - a) were deceased since referral to the agency
 - b) had moved and became unavailable
 - c) could appropriately be interviewed (state of health, mental condition, institutionalization, etc.)

The agency screening procedure eliminated 62 persons, yielding a list of 470 names, to which were added the 97 names of persons who had indicated to the New York State Commission that they did not want services. The Pilot Study staff, therefore, drew upon a total list of 567 legally blind persons for its sample.

IV. Contact Procedures

The initial contact with the legally blind person was through a letter from the New York State Commission for the Blind seeking the individual's participation in the research project. Where there were no refusals to participate, and where the letters were not returned indicating the persons had "moved, unavailable", the names were given to the interviewers, who then sent a second letter seeking a specific appointment. Following the second letter, it was found that a number of legally blind persons could not be interviewed for a variety of reasons; these totalled 91 (See Appendix, I., Page)

In addition to these eliminations, two arbitrary elimination procedures were undertaken by the Pilot Study staff: -

- 1) because of the pre-dominance of elderly persons in the screened list it was felt necessary, for an exploratory study, to guarantee the presence in the sample of sufficient numbers of younger persons to provide representation of feelings and attitudes of all legally blind persons within the age groups registered by the New York State Commission for the Blind. Thus, initially, the names of all persons over 70 years of age were excluded from the assignments to interviewers. As the names were used up by the interviewers, persons up to 80 years of age were added during the limited interviewing period of two months, but the assignment of the names of those over 70 did not reach the proportion of elderly which is representative of the blind population annually registered by the Commission; - and

- 2) an elimination procedure occurred where the residential location of the legally blind respondent was considered unsafe for an interviewer to visit. This may have resulted in an under-representation of extremely low-income persons in very undesirable neighborhoods in the Pilot Study sample as a whole. (See Characteristics, Appendix II., Page)

Although the sample of the Pilot Study was not designed to be statistically representative of the blind population registered with the New York State Commission for the Blind, it appears representative in the scope of attitudes and feelings of a variety of groups within the blind population.

1) The design of the system is based on the following principles:
a) The system is designed to be flexible and adaptable to changing requirements.
b) The system is designed to be secure and reliable.
c) The system is designed to be easy to use and maintain.
d) The system is designed to be cost-effective.

2) The system is designed to be flexible and adaptable to changing requirements.
a) The system is designed to be flexible and adaptable to changing requirements.
b) The system is designed to be secure and reliable.
c) The system is designed to be easy to use and maintain.
d) The system is designed to be cost-effective.

The system is designed to be flexible and adaptable to changing requirements.
a) The system is designed to be flexible and adaptable to changing requirements.
b) The system is designed to be secure and reliable.
c) The system is designed to be easy to use and maintain.
d) The system is designed to be cost-effective.

3) The system is designed to be flexible and adaptable to changing requirements.
a) The system is designed to be flexible and adaptable to changing requirements.
b) The system is designed to be secure and reliable.
c) The system is designed to be easy to use and maintain.
d) The system is designed to be cost-effective.

In addition to these principles, the system is designed to be flexible and adaptable to changing requirements.
a) The system is designed to be flexible and adaptable to changing requirements.
b) The system is designed to be secure and reliable.
c) The system is designed to be easy to use and maintain.
d) The system is designed to be cost-effective.

4) The system is designed to be flexible and adaptable to changing requirements.
a) The system is designed to be flexible and adaptable to changing requirements.
b) The system is designed to be secure and reliable.
c) The system is designed to be easy to use and maintain.
d) The system is designed to be cost-effective.

5) The system is designed to be flexible and adaptable to changing requirements.
a) The system is designed to be flexible and adaptable to changing requirements.
b) The system is designed to be secure and reliable.
c) The system is designed to be easy to use and maintain.
d) The system is designed to be cost-effective.

Although the design of the system is based on the following principles, the system is designed to be flexible and adaptable to changing requirements.
a) The system is designed to be flexible and adaptable to changing requirements.
b) The system is designed to be secure and reliable.
c) The system is designed to be easy to use and maintain.
d) The system is designed to be cost-effective.

V. Additional Representation in the Total Sample

It was hypothesized that family members of the legally blind persons and their friends might exert significant influence on the respondent's motivation to seek or accept service. For this reason, interviews with 15 influential collaterals (family members or close friends) was set as a goal. Because of limitations of time, only six collaterals were interviewed, five family members and one close friend. (See Appendix III., Page)

Likewise, the Pilot Study staff set an interviewing goal of 15 doctors, both ophthalmologists and/or general practitioners who were revealed by the blind respondents to have been in a position to affect the rehabilitation decisions of their patients. A pre-test of the interviewing instrument was conducted with one ophthalmologist. A total of nine additional ophthalmologists and four general practitioners, all associated with the blind respondents were interviewed.

As indicated in the "Introduction", members of an Advisory Committee, a Specialized Agencies Committee and a Committee of Directors of Hospital Social Service Departments contributed factual and conceptual material which have been incorporated into the pilot study.

VI. Definitions of Terms Used to Describe the Pilot Study Population and Respondents Interviewed

The total pilot study sample consists of the following:

Sample Segment - (65)

<u>No Service Received - (35)</u>	<u>Number Interviewed in Sample</u>
<u>No Service Desired</u> : those blind respondents who so indicated, to the New York State Commission for the Blind;	20
<u>Rejected Service</u> : blind respondents who verbally or in writing rejected the specialized agency's offer of service;	11
<u>No Response</u> : blind respondents who gave no response to the specialized agency's offer of service;	4
 <u>Service Cases - (30)</u>	
<u>In Service</u> : those respondents currently receiving services from one or more specialized agencies for the blind;	25
<u>Previous Service</u> : those respondents who received services from a specialized agency in the past;	1
<u>Reception/Pending</u> : those blind respondents with or for whom initial contact with the specialized agency has been made but service status had not been determined;	4

VII. Two Interviewing Phases

The Pilot Study was conducted in two phases: Phase I consisted of a pre-test of the interviewing instrument; Phase II included the main portion of the interviewing undertaken with a revised interviewing schedule. Inasmuch as the revisions consisted largely of deletions in the schedule to shorten the interviewing time rather than basic changes in the research areas, the pre-test interviews were included in the final sample.

It was hypothesized that family members of the family living together and family
Dad's wife would experience differences in the husband's behavior as well as
or more positive. The first family, therefore, is the family of the husband
(family members of the husband) and not as a whole. The husband of the husband
The wife and children were interviewed. The husband and the wife
Interview. The wife interviewed as an individual, but it is possible that she

Psychology with a degree in psychology. She was trained in the field of
to have been a graduate in which she received her degree in 1975.
The husband of the husband was interviewed. He was interviewed in 1975.
The husband of the husband was interviewed. He was interviewed in 1975.
Interview. All interviews with the husband and the wife were

in progress in the husband's home. The husband and the wife were interviewed
The husband and the wife were interviewed. The husband and the wife were interviewed
Interview. The husband and the wife were interviewed. The husband and the wife were interviewed

VI. Statistical Inference in the Social Sciences

The first two family members were interviewed.

Family Interview - (1)

Family Interview
Interview

Family Interview - (2)

The husband and the wife were interviewed. The husband and the wife were interviewed
The husband and the wife were interviewed. The husband and the wife were interviewed
The husband and the wife were interviewed. The husband and the wife were interviewed
The husband and the wife were interviewed. The husband and the wife were interviewed
The husband and the wife were interviewed. The husband and the wife were interviewed

Family Interview - (3)

The husband and the wife were interviewed. The husband and the wife were interviewed
The husband and the wife were interviewed. The husband and the wife were interviewed
The husband and the wife were interviewed. The husband and the wife were interviewed
The husband and the wife were interviewed. The husband and the wife were interviewed
The husband and the wife were interviewed. The husband and the wife were interviewed

VII. Statistical Inference in the Social Sciences

The first two family members were interviewed. The husband and the wife were interviewed
The husband and the wife were interviewed. The husband and the wife were interviewed
The husband and the wife were interviewed. The husband and the wife were interviewed
The husband and the wife were interviewed. The husband and the wife were interviewed
The husband and the wife were interviewed. The husband and the wife were interviewed

VIII. The Interviewing Staff

The interviewing staff consisted of: 1) eight professional staff members of the three participating specialized agencies for the blind, of whom four were social workers, two were rehabilitation counselors and two were members of the research staff of these agencies; 2) 44 second year students in social work reasearch classes from the Columbia University School of Social Work, and 13 students from similar classes from the Adelphi University School of Social Work*; and 3) the Assistant Director of the Pilot Study.

Several briefing and field report sessions were held with the interviewers associated with the specialized agencies for the blind, where interpretation and use of the interviewing instruments were discussed and goals clarified, both prior to and following the pre-test phase. Similar briefing sessions were held at Adelphi University School of Social Work, and conferences with the advisory and supervisory personnel at the Columbia University School of Social Work were undertaken. A classroom period of from six to eight weeks was employed by the schools of social work to study and clarify the interviewing instrument, to interview in the field and conduct classroom discussions of the students' findings. These discussions, together with the field work undertaken by the students, were directed by four professors of social work research.

The supervision and direction of that portion of the interviewing staff associated with the specialized agencies was undertaken jointly by the heads of Social Service departments within the agencies and members of the Pilot Study staff.

IX. The Interviewing Instrument

For the legally blind respondents, the non-medical collaterals and the physicians in the sample, semi-focused depth interviewing schedules composed of both directed and non-directed probes, were used.

Because of the exploratory nature of the Pilot Study the research staff sought a broad range of factual data, experiences in a large number of situations related to the visual handicap, feelings and attitudes toward a wide variety of problems arising from the visual loss. The interview with the legally blind persons took from one and a half to two hours to conduct, depending upon the responsiveness of the blind person and the skill of the interviewer. The interviews with family members and friends took approximately one hour to complete; those with physicians lasted from one half to three quarters of an hour.

In utilizing semi-focused depth interviews, it is usually the practice to structure as many of the logical extensions of the hypotheses uncovered as possible. In this way, an attempt is made to exhaust all possible avenues of response, thus extending considerably the number of clarified and new hypotheses and concepts available within the depth interviews for validation.

X. Data Analysis

For efficiency in analyzing factual data occurring within the depth interview, each interviewer was asked to enter on an especially prepared "tabulation sheet" the principal factual items (used with all persons included in the total sample) elicited from the respondent. In addition, each interviewer was asked to indicate

* (See list of Committees, Advisors and Interviewers, Page iv)

The laboratory staff consisted of 17 full-time members of staff. These full-time members were assigned to the clinic, of whom four were women, two were technical staff members and two were members of the research staff of the department. (The names of these members are given in the Appendix.) The laboratory staff consisted of 17 full-time members of staff, of whom four were women, two were technical staff members and two were members of the research staff of the department. (The names of these members are given in the Appendix.)

General practice and field reports received were held in the laboratory staff. The laboratory staff consisted of 17 full-time members of staff, of whom four were women, two were technical staff members and two were members of the research staff of the department. (The names of these members are given in the Appendix.)

The organization and division of labor within the laboratory staff consisted of 17 full-time members of staff, of whom four were women, two were technical staff members and two were members of the research staff of the department. (The names of these members are given in the Appendix.)

IX. The Laboratory Staff

The laboratory staff consisted of 17 full-time members of staff, of whom four were women, two were technical staff members and two were members of the research staff of the department. (The names of these members are given in the Appendix.)

Reasons of the laboratory staff of the field staff were the research staff and a broad range of clinical tests, equipment, a large number of patients treated in the laboratory. The laboratory staff consisted of 17 full-time members of staff, of whom four were women, two were technical staff members and two were members of the research staff of the department. (The names of these members are given in the Appendix.)

In addition, the laboratory staff consisted of 17 full-time members of staff, of whom four were women, two were technical staff members and two were members of the research staff of the department. (The names of these members are given in the Appendix.)

I. Data Analysis

The laboratory staff consisted of 17 full-time members of staff, of whom four were women, two were technical staff members and two were members of the research staff of the department. (The names of these members are given in the Appendix.)

his or her own evaluations of key aspects of the interviewing situation: personality factors of the respondent; the degree to which cooperation was evident; the physical setting of the respondent's home; any factors which may have biased the interview (interference or assumption of responses by a family member, etc.) A coding system based upon the key research areas of each interviewing schedule was developed, the responses tabulated and tables developed accordingly.

While a number of findings in key areas were correlated with what appeared to be significantly influential data, the clusters of responses in many correlations, because of the small sample size, were found to be statistically insignificant. Where they appeared to be important to further research and validation they have been indicated in the body of the study.

Because of the small size of the Pilot Study sample, only trends and directions rather than definitive findings can be reported. It cannot be overemphasized that the main value of the Pilot Study lies in its qualitative analysis, and in its implications for further research, rather than in the quantitative data reported.

In the data analysis, wherever there has been a subjective evaluation on the part of the Pilot Study staff, an attempt has been made to so indicate. Wherever there has been some question of the validity of the responses from the legally blind, the family collaterals and physicians, this has likewise been so indicated.

his or her own evaluation of the importance of the information provided. The degree of the respondent's concern is also related to the degree of the respondent's belief in the validity of the information. (Information is considered to be more valid if it is perceived to be more important.)

While a number of findings in this study were consistent with what is known in the literature, there were some differences. For example, the degree of concern in this study was generally lower than in previous studies. This may be due to the fact that the respondents in this study were more educated and had more knowledge about the risks of the information.

There are several limitations of this study. First, the sample was limited to a specific population. Second, the study was cross-sectional. Third, the study did not measure the degree of concern in a direct manner. Finally, the study did not measure the degree of concern in a longitudinal manner.

In the future, it would be interesting to see if the findings of this study can be replicated in other populations. It would also be interesting to see if the findings of this study can be replicated in a longitudinal manner. Finally, it would be interesting to see if the findings of this study can be replicated in a more direct manner.

CHAPTER III.

CHARACTERISTICS OF THE SAMPLE OF BLIND PERSONS INTERVIEWED

I. Profile of the Total Sample

An analysis of the total sample of the Pilot Study indicates that it is predominantly:

- male (66%)
- married (62%)
- elderly (63% over 60 years of age) This is similar to the proportion for the State. (61% over 60 years of age as classified in 1964.) However, the proportion of those between the ages of 40 and 59 in the Pilot Study is greater (32%) than those as classified by the State Commission (18.4%) in 1964*
- native born (64%) but with sufficient representation of foreign born to provide insights into ethnic and cultural patterns
- poorly educated, with 53% having no more than grammar school education
- unemployed (92%)
- white, but with a higher percentage of Negroes (22%) than exists in the New York City population
- low income with 49% below the poverty level (\$3,000) and 67% having less than \$5,000 annual income
- receiving some form of public funds as a source of personal income. (Combinations of: - Public Assistance (17%) - Social Security (41%) - public or private disability insurance (23%) - pension funds (12%))
- a group, living with members of their family (80% with spouse, children, or relatives
- a group with two or more persons (65%) living in the home
- a residentially non-mobile group with 57% living in their present arrangement over five years (26% from 5 to 20 years and 31% over 20 years)
- partially blind (97%)**

* "An Analysis of the Principal Causes of Blindness in New York State During 1964", New York State Commission for the Blind

** See footnote, Introduction, Page 2. In 1963 .06% of those reported to the New York State Commission were totally blind, in 1964 .07%.

ORGANIZATION OF THE BUREAU OF BUREAU INVESTIGATION

1. Review of the Total Budget

In order to be able to make a proper estimate of the total budget of the Bureau of Investigation it is necessary to consider the following factors:

— Total (1933)

— Total (1934)

— Total (1935) (All items of the Bureau of Investigation for the year 1935 are included in this total, however, the portion of the total which is included in the total for the year 1934 is indicated by the asterisk (*) in the following table.)

— Total (1936) (All items of the Bureau of Investigation for the year 1936 are included in this total, however, the portion of the total which is included in the total for the year 1935 is indicated by the asterisk (*) in the following table.)

— Total (1937) (All items of the Bureau of Investigation for the year 1937 are included in this total, however, the portion of the total which is included in the total for the year 1936 is indicated by the asterisk (*) in the following table.)

— Total (1938)

— Total (1939) (All items of the Bureau of Investigation for the year 1939 are included in this total, however, the portion of the total which is included in the total for the year 1938 is indicated by the asterisk (*) in the following table.)

— Total (1940) (All items of the Bureau of Investigation for the year 1940 are included in this total, however, the portion of the total which is included in the total for the year 1939 is indicated by the asterisk (*) in the following table.)

— Total (1941) (All items of the Bureau of Investigation for the year 1941 are included in this total, however, the portion of the total which is included in the total for the year 1940 is indicated by the asterisk (*) in the following table.)

— Total (1942) (All items of the Bureau of Investigation for the year 1942 are included in this total, however, the portion of the total which is included in the total for the year 1941 is indicated by the asterisk (*) in the following table.)

— Total (1943) (All items of the Bureau of Investigation for the year 1943 are included in this total, however, the portion of the total which is included in the total for the year 1942 is indicated by the asterisk (*) in the following table.)

— Total (1944) (All items of the Bureau of Investigation for the year 1944 are included in this total, however, the portion of the total which is included in the total for the year 1943 is indicated by the asterisk (*) in the following table.)

— Total (1945)

* The figures of the Budget Bureau of the Department of Justice for the years 1933-1945, are the total budget for the Bureau of Investigation.

** The figures of the Budget Bureau of the Department of Justice for the years 1933-1945, are the total budget for the Bureau of Investigation.

II. Significant Differences Between the No Service Received Segment and the Service Cases

Age: Those in the No Service Received segment are considerably older than the Service Cases. It is interesting to note that 56% of the Service Cases are under 60 years of age, compared with 20% not receiving service.

Education: Only half as many in the No Service Received segment (26%) had an education of completed high school and beyond as compared with the Service Cases (53.5%).

Race: The proportion of Negro respondents among the No Service Received segment is lower (11%) than among the Service Cases (33%).

Household Income: A higher proportion (84%) of the No Service Received segment have incomes under \$5,000 than the Service Cases (57%).

Length of Time in Present Living Arrangement: The proportion of those in the No Service Received segment living in their present arrangement beyond five years is larger (53%) as compared with the Service Cases (26%).

Number of Children Living: Persons in the No Service Received segment, although older, have a larger number of children living (57% from two to four living children) as compared with the Service Cases (34% two to four children living). Correspondingly, in the No Service Received segment only 20% of the respondents have "no children" living as compared with 47% of the Service Cases who have no children living.

17. Statistical Data on the Service Sector and the
Service Sector

The data in the Service Sector are consistently higher than the
service sector. It is interesting to note that 50% of the service sector
data is based on the comparison with 1981 and 1982 service.

Statistical data is also in the Service Sector (1981) and in
the comparison of statistical data and figures in comparison with the Service Sector
(1981).

The comparison of the data in the Service Sector and the
in 1981 (1981) and the Service Sector (1981).

Statistical data is also in the Service Sector (1981) and in
the comparison of statistical data and figures in comparison with the Service Sector
(1981).

The comparison of the data in the Service Sector and the
in 1981 (1981) and the Service Sector (1981).

Statistical data is also in the Service Sector (1981) and in
the comparison of statistical data and figures in comparison with the Service Sector
(1981).

CHAPTER IV.

FINDINGS AND IMPLICATIONS RELATED TO EARLY REHABILITATION SERVICES AFTER THE ONSET OF BLINDNESS

Introduction

This chapter brings together the comments, factual information and recommendations provided on an interview or conference basis by; - sixty five legally blind persons; sixteen doctors; seven hospital medical social work program directors; six supervisors or consultants of service programs for the blind and ten executives of specialized and non-specialized rehabilitation agencies in New York City.

The problems presented and information sought were, as reviewed in the earlier chapters of this report, extremely complex. The breadth of exploration required an arbitrary grouping in the presentation of the material. It was decided to group the findings into sections relating to influences which appear to be most inhibiting in the seeking and utilization of available rehabilitation services by legally blind persons.

There were innumerable instances of effective positive influences which have resulted in a countless number of blind persons currently receiving, or having received in the past, excellently conceived and operating rehabilitation services. However, since the focus of this Pilot Study is on the "inhibiting" influences, the emphasis is on those attitudes, philosophy, policies and practices which have negative connotations.

One of the major questions which was posed at the initiation of the project was - are those persons who have said specifically they desire no service - or who have not responded to an offer of service - in need of service? The subjective evaluation of the members of the Pilot Study staff after reading all of the interviews is that 88% of those who have received no service would have been advantaged to some degree if they had accepted one or more of the rehabilitation services available from specialized agencies.

THEORY AND PRACTICE OF THE ADAPTATION OF THE CURRICULUM

Introduction

This chapter begins with a review of the theoretical foundations of curriculum adaptation. It discusses the relationship between the curriculum and the learner, and the role of the teacher in the process. The chapter also examines the various factors that influence the adaptation of the curriculum, such as the learner's individual characteristics, the learning environment, and the available resources.

The first part of the chapter focuses on the theoretical aspects of curriculum adaptation. It discusses the concept of the curriculum as a dynamic process that evolves over time and in response to the needs of the learners. The chapter also explores the different models of curriculum adaptation, such as the individualized curriculum, the modular curriculum, and the competency-based curriculum.

The second part of the chapter discusses the practical aspects of curriculum adaptation. It examines the various strategies and techniques that can be used to adapt the curriculum to the needs of individual learners. The chapter also discusses the role of the teacher in the process of curriculum adaptation, and the importance of ongoing assessment and evaluation.

The final part of the chapter discusses the challenges and opportunities of curriculum adaptation. It examines the various barriers to the implementation of adapted curricula, such as the lack of resources, the resistance of teachers and administrators, and the limited support of parents and the community. The chapter also discusses the potential benefits of curriculum adaptation, such as the increased motivation and achievement of individual learners, and the development of a more inclusive and equitable educational system.

SECTION A

HOW EXTENSIVE IS THE GAP BETWEEN ONSET OF SERIOUS EYE CONDITION AND THE OFFERING OF REHABILITATION SERVICES?

The Gap

Based on the reports of the blind persons interviewed, the gap is indeed extensive with one half of those interviewed falling into the three to over twenty years group.

The following table therefore confirms the original assumption that for a significant number of persons there appears to be a long delay between onset of serious eye difficulty and referral for rehabilitation services. For only twenty five percent (25%) was the time gap less than a year.

Table #1

TIME GAP BETWEEN DEVELOPMENT OF SERIOUS EYE CONDITION AS REPORTED BY BLIND RESPONDENTS, AND OFFER OF SPECIALIZED SERVICES (THROUGH THE REFERRAL SYSTEM OF THE NEW YORK STATE COMMISSION FOR THE BLIND)

	TOTAL Sample (N-65)		No Service Received (N-35)		Service Cases (N-30)	
	N	%	N	%	N	%
Less than 6 months	9	14	2	6	7	23
6 months - 11 months	7	11	5	14	2	7
1 year - 2 years	11	17	5	14	6	19.5
3 years - 5 years	12	18	6	17	6	19.5
6 years - 10 years	13	20	8	23	5	17
11 years - 20 years	4	6	4	11	-	-
over 20 years	4	6	2	6	2	7
Information not obtained	5	8	3	9	2	7
Total	65	100	35	100	30	100

The above table (#1) also tends to support the belief that early referral after onset is a factor in whether or not service from a specialized agency is accepted. 50% of the Service Cases experienced a time gap of less than three years while in the No Service Received group the majority (57%) experienced a time gap of over three years. There are obviously many interrelated factors which have an effect not only on early referral to a specialized agency but more importantly on the utilization of the agency's rehabilitation services after referral. Both will be discussed in the following sections of this chapter.

How Are Referrals Made?

A brief explanation of how persons get to agencies for service may be helpful as background in analyzing the time gap between serious eye difficulty and the offer of service. Visually handicapped persons usually come to the attention of specialized service agencies for the blind in New York City in one of four ways. Self-referral - or the direct seeking out of the agency by the visually handicapped

SECTION 1

THE NITROGEN IN THE GUT CONTENT OF THE BIRD AND THE
RELATIONSHIP TO THE NITROGEN IN THE GUT

The bird

Based on the reports of the bird content laboratory, the bird is found to contain
with one half of those nitrogen values as the bird is very young.

The following table shows the nitrogen content of the bird content laboratory
and shows the nitrogen content of the bird content laboratory. The nitrogen content
of the bird content laboratory is very low. The nitrogen content of the bird
content laboratory is very low.

Table 1

Table 1. The nitrogen content of the bird content laboratory. The nitrogen content
of the bird content laboratory is very low. The nitrogen content of the bird
content laboratory is very low.

Age (years)	Nitrogen content (g/g)	Standard deviation (g/g)	Significance (p)
1	0.15	0.02	0.05
2	0.18	0.03	0.02
3	0.20	0.04	0.01
4	0.22	0.05	0.005
5	0.25	0.06	0.001
6	0.28	0.07	0.0005
7	0.30	0.08	0.0001
8	0.32	0.09	0.00005
9	0.35	0.10	0.00001
10	0.38	0.11	0.000005
11	0.40	0.12	0.000001
12	0.42	0.13	0.0000005
13	0.45	0.14	0.0000001
14	0.48	0.15	0.00000005
15	0.50	0.16	0.00000001

The above table (1) shows the nitrogen content of the bird content laboratory. The nitrogen content
of the bird content laboratory is very low. The nitrogen content of the bird
content laboratory is very low.

The nitrogen content

A is the nitrogen content of the bird content laboratory. The nitrogen content
of the bird content laboratory is very low. The nitrogen content of the bird
content laboratory is very low.

person himself; referral by relatives or friends; referral by professional personnel engaged in social welfare, educational or health activities; and the referral policy of the New York State Commission for the Blind. The New York State law mandates that all persons who fall within the legal definition of blindness must be reported by ophthalmologists and other professional personnel to the New York State Commission for the Blind. When a person in New York City is registered as legally blind and it is not apparent that he is already known to an agency for the blind, the Commission sends him a letter (See Appendix III.) advising him about resources in the community and tells him his name will be referred to an agency unless he indicates that he has no desire for service. In this Pilot Study the time gap was computed for the period between the time the blind respondent stated his eye condition became serious and the time the Commission for the Blind advised him concerning the availability of agency services.

Delays Which Are Unavoidable

In considering the gap, it should be noted that there are some delays which may be inherent in the problem itself. For example, some adjustment time (sometimes referred to as the "mourning period") may be needed before the legally blind person is ready to move into the service program of a specialized agency. This is not intended to imply the rehabilitation process is therefore delayed, but rather it should ideally have already begun in the doctor's office. The blind person may need time to work through his psychological difficulties in accepting his medical condition. This delay cannot always be managed. Many persons in addition to the ophthalmologist may be involved in this initial stage - hospital or clinic medical social workers, family members, general practitioners and other experts who may have been called in.

When the point of referral to a specialized agency for the blind is reached, some delay may be due to procedural aspects. For example, the current referral practice of many doctors involves the submission of an eye report to the Commission, where it is reviewed and classified; communication by the Commission with a legally blind person; a period of waiting for his reply; referral to an agency; the assignment of an agency worker; the making of an appointment etc.

Delays are occasioned by many other factors. The difficulty of diagnosis of some eye diseases and the unpredictability of the success of treatment or surgery may result in delayed planning. In a community like New York City where there is a very high degree of mobility, failure to locate represents a serious problem and may not only cause delay but sometimes results in persons falling into a "hidden" or "lost" group. For example, during the Pilot Study it was not possible to locate 12% of the persons to whom letters were sent (31 of the 252 persons). Still another group for whom referral and/or services may be delayed are those with mental or other illnesses which makes them inaccessible. For some of these persons the severity of, or a concentration on, other disabilities may preclude services relating to vision which are considered secondary in importance .

Unnecessary Delays

While some delay in connection with each of the above may be considered as inherently difficult to change, it was nevertheless found that for each there were illustrations of prolonged or inappropriate delays which possibly could have been avoided.

The most tragic of all delays is probably the one of late diagnosis and treatment

which results in blindness. Two respondents mentioned spontaneously that had their eyes been examined while they were children, it would have been possible with adequate treatment to have conserved some of their sight which is now irretrievably lost. Examples of other delays include evidence that some doctors are not sending in eye reports as legally required; some eye reports are not sent promptly; some diagnoses are delayed because of the patient's "shopping around"; some persons who have moved are not located because of the agency's failure to follow up; some persons who are physically unable to make an office visit to an agency are not sought out at their own homes. The majority of these avoidable delays will be discussed in later sections.

The time period involved in agency processing needs special review, that is, the time required for each step between the physician's decision that his patient has a serious eye handicap until he is seen by a professionally trained worker who can interpret, in the light of his individual needs, the rehabilitation services which are available to him. Although it was not possible to include a detailed analysis during the Pilot Study, it was apparent that a few days between each step added up to several months in some instances. A special study appears to be needed of "processing" methods and the ways in which this time gap can be reduced to a minimum. The use of a standard letter by the New York State Commission for the Blind, which informs newly registered blind persons about the availability of rehabilitation services, is also in need of reevaluation both in wording and as a communicating device. The responses of blind persons in the sample raise serious questions concerning its effectiveness. (See Appendix III, - sample copy of letter)

Delays which possibly could have been avoided are illustrated by the following comments of an interviewer and three blind respondents: -

"The (X agency) people were up here once. Through the Veterans they got my name. They said they couldn't send anyone up here. If I went there it would be O.K. But I didn't want anything anyway. I'm satisfied this way as long as I can get around."

"Respondent said his first introduction to services to the blind came from his sister who suggested he join the (X agency). He had an intake interview but 'never heard from them again'. Two years elapsed until a social worker at Columbia Presbyterian Hospital again suggested the (X agency)".

"I was having so much trouble getting around that one day I called up Welfare and asked them, who helps blind people?" (A social worker from Welfare referred her to the X agency.)

"I also signed a card saying I was interested in recreation you know camps and things like that, but I never heard any more from them ... Yes, the (agency) people sent me a card about a clinic meeting for low vision lenses. I am going to that. (Mr. M's wife reminded him that had been two years ago.) Yes, but they said they'd get in touch with me. A woman called and said she'd let me know when to come."

SECTION B

WHAT ARE THE MAJOR REASONS WHY MANY VISUALLY HANDICAPPED PERSONS DO NOT SEEK REHABILITATION SERVICES PROMPTLY OR UTILIZE THEM WHEN THEY ARE OFFERED?

The blind respondents gave a number of reasons why they were not interested in services and implied many others. After reading a sample group of interviews a list of twenty five factors which may cause or influence the time gap between the onset of blindness and the seeking of specialized rehabilitation services, were identified. This list was reviewed by the social work and rehabilitation staff of The Jewish Guild for the Blind and the selected group of Hospital Social Service Department Directors. In discussion sessions, they were asked to select from the list of twenty five, the six most inhibiting factors in the seeking of service based on their own experience in working with legally blind persons. The table on the following page indicates their choices and four factors which were subsequently added.

The factors selected fell into three major groupings:

1. Factors directly related to the person's own view and adjustment to visual loss. All three professional groups chose the following as among the six most important factors: -
 - Unwillingness and/or inability to accept visual handicap (legal blindness)
 - False hope that eye condition will improve
 - Gradual progression in loss of sight (which allows for gradual accommodation)
2. Factors primarily related to attitudes, either of the blind person or his family or friends: -
 - Toward blindness (stigma, protectiveness, guilt, shame etc.)
 - Toward acceptance of services from a voluntary agency (charity concept, client role, ethnic groups served etc.)
 - Toward segregation of the blind
3. Factors related to general personality patterns: -
 - Apathy
 - Lack of motivation
 - Resistance to change
 - Need to retain a dependent role

In addition to the above, the lack of knowledge about the nature of specialized services (including the assumption that services are for the totally blind) was considered a major factor in the failure to seek service.

A subjective evaluation of the verbal statements made by blind respondents would tend to confirm the above judgements arrived at on the basis of experience by the professional staff groups. It is questionable whether the reason for the gap in any individual case can be attributed to one factor. Generally, a combination of interrelated factors requires careful sorting and study. A major goal of the Pilot Study has been to obtain a better understanding of the facets of the problem and to determine which of the varied interrelationships are most significant. This aspect of the study will be further discussed in the separate sections of the findings.

ARTICLE IV - THE BOARD OF DIRECTORS

The Board of Directors shall have the honor of a number of members who shall be elected in a... view and limited term of office. After making a certain number of members a list... of twenty five members shall be made or authorized members and twenty five... of members and the number of members shall be determined by the Board... also. This list shall be subject to the power of the Board and shall be subject to... terms shall be the Board and the Board shall have the power to elect or... members. In addition, the Board shall have the power to elect or... list of twenty five members shall be made or authorized members and twenty five... shall be subject to the power of the Board and shall be subject to... the following provisions shall be subject to the power of the Board and shall be subject to... also.

The Board of Directors shall have the honor of a number of members who shall be elected in a...

1. The Board of Directors shall have the honor of a number of members who shall be elected in a... also. All such members shall be subject to the power of the Board and shall be subject to... also.

2. The Board of Directors shall have the honor of a number of members who shall be elected in a... also. The Board shall have the power to elect or... also.

3. The Board of Directors shall have the honor of a number of members who shall be elected in a... also. The Board shall have the power to elect or... also.

4. The Board of Directors shall have the honor of a number of members who shall be elected in a... also. The Board shall have the power to elect or... also.

5. The Board of Directors shall have the honor of a number of members who shall be elected in a... also. The Board shall have the power to elect or... also.

6. The Board of Directors shall have the honor of a number of members who shall be elected in a... also. The Board shall have the power to elect or... also.

Factors Which May Cause or Influence the Time Gap Between the Onset of
Blindness and the Seeking of Specialized Rehabilitation Services

Factors Most Frequently Chosen From Among Twenty Five Factors
Ranked in Order of Their Choice
By The

Social Work and Rehabilitation Staff of The Jewish Guild for the Blind
and a Selected Group of Directors of Hospital Social Service Departments

<u>Most Significant Factors re Seeking Services</u>	<u>Six Most Frequently Chosen</u>		
	<u>15 Soc. Workers</u>	<u>10 Rehab Workers</u>	<u>7 Hosp Soc. Serv. Dir.</u>
- Unwillingness and/or inability to accept visual handicap (legal blindness)	1	1	3(a)
- False hope that eye condition will improve	2	2	1
- Need to retain dependent role (fear of responsibility for self)	3	-	-
- Apathy or lack of motivation (general)	-	3	2
- Resistance to any type of new experience or change (general)	-	-	3(b)
- Lack of knowledge about the <u>nature</u> of available specialized services (including assumption that services are for totally blind and not for the partially blind or those with "usefull" vision)	4	-	-
- Attitude of family and/or friends toward blindness (protectiveness, guilt, shame, stigma, etc.)	-	4	-
- Attitude toward segregation of the blind	-	-	3(c)
- Attitude of <u>blind person</u> toward the acceptance of service from a voluntary social or health agency (charity concept, stigma, client role, ethnic groups served etc.)	5	6	-
- Gradual progression in loss of sight	6	5	3(d)

Additional Factors from Which Choices Were Made

- * Lack of knowledge about the availability of specialized services
- Attitude of family and/or friends toward the acceptance of services from a voluntary social or health agency (charity concept, client role, ethnic groups served etc.)
- Need to remain independent (compulsive independence)
- Physical inability to contact agency (homebound)
- Concentration on other disabilities to the exclusion of blindness (blindness secondary handicap)
- Satisfaction with personal and social adjustments made to loss of vision without the aid of specialized agency
- Intellectual inability to understand services
- Cultural barriers (familial containment)
- Financial impoverishment as a deterrent in seeking help
- Attitude of doctor(s) toward blindness
- Attitude of doctor(s) toward rehabilitation services
- Negative experience with non-specialized social or health agencies
- Negative experience with specialized agencies for the blind
- Acceptance of blindness as the will of God or as the punishment for sin
- Language barriers

Factors Subsequently Added

- Acceptance of blindness as part of the natural process of aging
- Agency delay in handling service request
- Delay in adequate medical diagnosis
- Deprivation of elderly of services by children or relatives

Section 101 - General Provisions

Section 101.1 - Definitions

Section 101.2 - Purpose of the Act

Section	Text
101.1	Definitions
101.2	Purpose of the Act
101.3	...
101.4	...
101.5	...
101.6	...
101.7	...
101.8	...
101.9	...
101.10	...
101.11	...
101.12	...
101.13	...
101.14	...
101.15	...
101.16	...
101.17	...
101.18	...
101.19	...
101.20	...
101.21	...
101.22	...
101.23	...
101.24	...
101.25	...
101.26	...
101.27	...
101.28	...
101.29	...
101.30	...
101.31	...
101.32	...
101.33	...
101.34	...
101.35	...
101.36	...
101.37	...
101.38	...
101.39	...
101.40	...
101.41	...
101.42	...
101.43	...
101.44	...
101.45	...
101.46	...
101.47	...
101.48	...
101.49	...
101.50	...

Section 102 - Administration

Section 102.1 - Administration

- Section 102.1.1 - Administration
- Section 102.1.2 - Administration
- Section 102.1.3 - Administration
- Section 102.1.4 - Administration
- Section 102.1.5 - Administration
- Section 102.1.6 - Administration
- Section 102.1.7 - Administration
- Section 102.1.8 - Administration
- Section 102.1.9 - Administration
- Section 102.1.10 - Administration
- Section 102.1.11 - Administration
- Section 102.1.12 - Administration
- Section 102.1.13 - Administration
- Section 102.1.14 - Administration
- Section 102.1.15 - Administration
- Section 102.1.16 - Administration
- Section 102.1.17 - Administration
- Section 102.1.18 - Administration
- Section 102.1.19 - Administration
- Section 102.1.20 - Administration
- Section 102.1.21 - Administration
- Section 102.1.22 - Administration
- Section 102.1.23 - Administration
- Section 102.1.24 - Administration
- Section 102.1.25 - Administration
- Section 102.1.26 - Administration
- Section 102.1.27 - Administration
- Section 102.1.28 - Administration
- Section 102.1.29 - Administration
- Section 102.1.30 - Administration
- Section 102.1.31 - Administration
- Section 102.1.32 - Administration
- Section 102.1.33 - Administration
- Section 102.1.34 - Administration
- Section 102.1.35 - Administration
- Section 102.1.36 - Administration
- Section 102.1.37 - Administration
- Section 102.1.38 - Administration
- Section 102.1.39 - Administration
- Section 102.1.40 - Administration
- Section 102.1.41 - Administration
- Section 102.1.42 - Administration
- Section 102.1.43 - Administration
- Section 102.1.44 - Administration
- Section 102.1.45 - Administration
- Section 102.1.46 - Administration
- Section 102.1.47 - Administration
- Section 102.1.48 - Administration
- Section 102.1.49 - Administration
- Section 102.1.50 - Administration

Section 103 - Enforcement

- Section 103.1 - Enforcement
- Section 103.2 - Enforcement
- Section 103.3 - Enforcement
- Section 103.4 - Enforcement
- Section 103.5 - Enforcement
- Section 103.6 - Enforcement
- Section 103.7 - Enforcement
- Section 103.8 - Enforcement
- Section 103.9 - Enforcement
- Section 103.10 - Enforcement
- Section 103.11 - Enforcement
- Section 103.12 - Enforcement
- Section 103.13 - Enforcement
- Section 103.14 - Enforcement
- Section 103.15 - Enforcement
- Section 103.16 - Enforcement
- Section 103.17 - Enforcement
- Section 103.18 - Enforcement
- Section 103.19 - Enforcement
- Section 103.20 - Enforcement
- Section 103.21 - Enforcement
- Section 103.22 - Enforcement
- Section 103.23 - Enforcement
- Section 103.24 - Enforcement
- Section 103.25 - Enforcement
- Section 103.26 - Enforcement
- Section 103.27 - Enforcement
- Section 103.28 - Enforcement
- Section 103.29 - Enforcement
- Section 103.30 - Enforcement
- Section 103.31 - Enforcement
- Section 103.32 - Enforcement
- Section 103.33 - Enforcement
- Section 103.34 - Enforcement
- Section 103.35 - Enforcement
- Section 103.36 - Enforcement
- Section 103.37 - Enforcement
- Section 103.38 - Enforcement
- Section 103.39 - Enforcement
- Section 103.40 - Enforcement
- Section 103.41 - Enforcement
- Section 103.42 - Enforcement
- Section 103.43 - Enforcement
- Section 103.44 - Enforcement
- Section 103.45 - Enforcement
- Section 103.46 - Enforcement
- Section 103.47 - Enforcement
- Section 103.48 - Enforcement
- Section 103.49 - Enforcement
- Section 103.50 - Enforcement

SECTION C

SOCIAL STIGMA ATTACHED TO BLINDNESS -- THE MOST SERIOUS DETERRENT?

Introduction

Professional workers in agencies for the blind have indicated over a long period of time that a major barrier to the seeking or acceptance of rehabilitation services is the "non-acceptance" of blindness, by which they mean the psychological inability of the blind individual to recognize that he has a handicap which interferes with normal functioning. This became an initial hypothesis for the Pilot Study.

The research findings confirm this hypothesis, and at the same time reveal that the problem is a particularly complex one. The difficulty appears to be rooted not only in a psychological incapacity to accept the handicap but also in two other inter-related phenomena:

- 1) in the negative attitudes, i.e. the "stigma" with which society views blindness -- attitudes which, to varying degrees, the blind individual has incorporated within himself, and
- 2) the confusion which results from the absence of a functional definition of blindness. The overwhelming majority of the legally blind have either some partial sight or light perception. The presence of residual vision is an important factor that differentiates these persons in their functioning from the totally blind. It also becomes a means used to avoid the stigma attached to blindness per se.

An analysis of the interviews suggests that the individual's apparent refusal to accept his blindness is often, in actuality, a demonstration of his effort to retain his place in a "normal" world. It is used as a shield against the negative characterizations of "helplessness", "uselessness", "abnormality", "stupidity", and "pitifulness", which society attributes to blindness. It is used to resist the tendency of society to see him not as an individual who happens to be blind, but rather in terms of a category, i.e. a blind individual, which denies him identity as an individual.

The blind person's psychological and social functioning would seem to be patterned in a large part on these complicated efforts to retain his individuality, both in terms of his social and his self-image. This appears in the study to have profound effects upon his attitudes toward rehabilitation services.

The desire to maintain this identity, i.e. not to be categorized - typical of many respondents in the sample, is strongly expressed by a legally blind woman in her seventies, economically secure, well-educated, in excellent health and active in a wide variety of social and philanthropic organizations. She comments:

"I don't consider myself blind because I can still go out alone. I would rather die than be completely blind. I am not afraid to die. The doctors however tell me that I won't ever be blind, but I don't know whether this is just to be encouraging to me."

Another respondent indicates his desire to maintain his place in a normal world:

THE PSYCHOLOGICAL BASIS OF THE PSYCHOLOGICAL BASIS

[Illegible]

Professional workers in various fields have indicated over a long period of time that a major barrier to the progress of psychology as a scientific discipline is the "non-empirical" or "theoretical" nature of the psychological literature. The literature in this field is characterized by a lack of empirical evidence and by a lack of logical reasoning. This means an initial barrier to the field.

The necessary training within the psychological field is not only that the student is a scientific worker, but also that the student is a worker in the field. It is a psychological worker in the field, not a worker in the field.

1] In the psychological literature, the "theoretical" or "non-empirical" nature of the literature is a major barrier to the progress of the field. This means an initial barrier to the field.

2] The scientific method is the basis of a scientific discipline. The scientific method is the basis of the scientific method. The scientific method is the basis of the scientific method. The scientific method is the basis of the scientific method.

An analysis of the literature indicates that the scientific method is the basis of the scientific method. The scientific method is the basis of the scientific method. The scientific method is the basis of the scientific method. The scientific method is the basis of the scientific method.

The scientific method is the basis of the scientific method. The scientific method is the basis of the scientific method. The scientific method is the basis of the scientific method. The scientific method is the basis of the scientific method.

The scientific method is the basis of the scientific method. The scientific method is the basis of the scientific method. The scientific method is the basis of the scientific method. The scientific method is the basis of the scientific method.

The scientific method is the basis of the scientific method. The scientific method is the basis of the scientific method. The scientific method is the basis of the scientific method. The scientific method is the basis of the scientific method.

The scientific method is the basis of the scientific method. The scientific method is the basis of the scientific method. The scientific method is the basis of the scientific method. The scientific method is the basis of the scientific method.

"Yes, (with a chuckle), my family and friends think I am blind but I don't think so at all. I only have poor eyesight and I don't let them forget it ---."

I. The Rejection Of Blindness And Of The Relationships Associated With It

a. Own Estimate of Sight

In an effort to determine the extent to which non-acceptance of their blindness contributes to the gap between the onset of visual loss and the acceptance of services, the respondents were asked a series of questions about their eyesight:

How much trouble would you say you have seeing at the present time:
(a) a great deal of trouble? (b) some trouble? (c) little trouble?

To what extent can you read a newspaper at the present time? Do you have special glasses for this purpose?

Sometimes people who have difficulty seeing are considered "blind" and sometimes they are not. Do your friends and family think of you as "blind"?

And how about yourself -- do you consider yourself "blind", or not?
(If answer is "yes", then probe:) About when did you begin to think of yourself as "blind"?

The research findings indicate that there is an over-all rejection of blindness and its implications by approximately half the sample. As the accompanying tables #3, #4, and #5, illustrate:

- the majority of respondents (55%) do not consider themselves "blind"* nor do approximately half (51%) of their family members and/or friends consider the respondent "blind" (as reported by blind respondents)
- the majority of the respondents (54%) reject the word "blind" as an appropriate description of their visual handicap. Of these, a much higher proportion of those in the No Service Received segment (68%) reject the word "blind" than of the Services Cases (37%)

The words and phrases used most frequently by respondents to describe their visual handicap are: "partial vision"; "peripheral vision"; "tunnel vision"; "almost blind"; "semi-blind"; "partial blindness"; "visually handicapped"; "trouble seeing"; "eye trouble"; "poor eyesight"; "myopia"; "partially blind - I have glaucoma"; "have cataracts -- temporary difficulty"; "retinal hemorrhage"; "I wouldn't know what to call myself"; "I wouldn't know, it puzzles me".

* "In a four state survey of 684 legally blind persons 20 years of age and over, conducted by the American Foundation for the Blind, half of the respondents said that they did not consider themselves 'blind'", A Pilot Study of Visual Impairment, (Eric Josephson, Principal Investigator), American Foundation for the Blind, New York, N.Y. 1965, footnote, page 31.

Table #3

Respondent's Own Estimate of Sight (Legally Blind)

	TOTAL Sample (N-65)		No Service Received (N-35)		Service Cases (N-30)	
	N	%	N	%	N	%
Consider themselves "Blind"	29	45	14	40	15	50
Do not consider themselves "Blind"	36	55	21	60	15	50
Total	65	100	35	100	30	100

Table #4

Families' and Friends' Estimate of Legally Blind Respondents' Sight
(As Reported by Blind Respondents)

Consider respondent "Blind"	22	34	10	29	12	40
Do not consider respondent "Blind"	33	51	20	57	13	43
Information not obtained	10	15	5	14	5	17
Total	65	100	35	100	30	100

Table #5

Reaction of Respondents To The Use of Word "Blind" in Relation to Themselves

Accept word "Blind"	22	34	10	29	12	40
Do not accept word "Blind"	35	54	24	68	11	37
Information not obtained	8	12	1	3	7	23
Total	65	100	35	100	30	100

It was not possible within the framework of the Pilot Study to determine the basis for this difference in the two sample segments. A number of possibilities are suggested for further research: 1) that those who have received services experience a mediation of their non-acceptance of blindness while in service; 2) that basically different attitudes toward acceptance of blindness have initially motivated the acceptance or seeking of service; 3) that the acceptance on the part of those in service is one phase in their psycho-social development and becomes operative during the period of receiving services.

The establishment of definitive medical, visual, psychological and social differences between these two groups of "acceptors" and "non-acceptors" might offer significant insights into ways of closing the time gap between onset of blindness and reception of rehabilitation services.

Perhaps the most significant indicator in these tables is that half of the

Service Cases consider themselves blind, but half do not. A definitive understanding of the differences between these two groups would also appear to provide insights into the nature of the functional and psychological values implied by the acceptance of rehabilitation services.

b. Response to Blind Relationships and Segregated Activities

In order to determine the extent to which identification with other blind persons or with activities (in the specialized agencies) in which the participants are for the most part blind, is a barrier to rehabilitation, the interviewers asked the following questions of the blind respondents:

(Knowing Other Persons with Poor Vision)

Some people we have talked with say that knowing other people with eye trouble is a big help. How do you feel about this?

To what extent do you come in contact with people who have trouble seeing? Are any of them close friends? In what ways do you enjoy their company? In what ways do you find their company not completely satisfactory?

To what extent would you like to know other people who, like you, have trouble seeing? What are some of the things you feel you might get out of knowing such people?

On the other hand, to what extent do you like to be with people with normal sight? What are some of the satisfactions you get from being with these people?

To what extent do you have a preference for being with sighted or with persons with a visual handicap? Would you please give your reasons for your choice.

(Groups/Clubs Organizations of People with Visual Problems)

A lot of people who cannot see well, feel that it is better to have their own clubs and groups made up of people with visual problems. On the other hand, some people with serious eye trouble have told us that it is better to be with people who can see normally, to be in the same groups as they were in before their eyesight became a problem.

Why do you suppose some people feel that all those with eyesight problems should stick together?

On the other hand, what do you suppose are the reasons why some people don't join groups that are organized for people who have trouble seeing?

What are your own feelings about this question?

a.1. Rejection of Relationships With Other Blind Persons

The research findings reveal that the negative feeling toward relationships with other blind persons and toward activities in which the blind and sighted are separated in the agencies is even greater than the respondents' rejection of their "blindness".

...the ... of ...

... ..

... ..

... ..

... ..

... ..

... ..

... ..

... ..

... ..

... ..

... ..

... ..

... ..

... ..

As indicated on the accompanying table (Table#6)

- less than one fifth (19%) of the total sample indicate clearly positive responses to relationships with other blind persons
- among the Service Cases, the relationship between positive and negative responses is fairly balanced (50% "Positive" combined with "Both" versus 64% "Negative" combined with "Both", although it would appear important to note the content of the negative responses in terms of potential improvements in the relationships within the agencies.
- among those not receiving service, the weight of the negative responses (77% "Negative" combined with "Both" relationships with blind persons outweigh the positive responses (40% "Positive" combined with "Both") by almost two to one.

It would appear from these indications that for Service Cases, their contacts with a specialized agency may have had a mediating effect upon their personal relationships with other blind persons, but for those not receiving services, the possibility of such contacts is an inhibiting factor in the seeking of rehabilitation services.

Table #6

Attitudes of Blind Respondents Toward Relationships With Other Blind Persons

	TOTAL Sample (N-65)		No Service Received (N-35)		Service Cases (N-30)	
	N	%	N	%	N	%
Positive	12	19	5	14	7	23
Negative	29	44	18	51	11	37
Both*	17	26	9	26	8	27
Ambivalent	1	2	-	-	1	3
Non-committal	6	9	3	9	3	10
Total	65	100	35	100	30	100

2. Rejection of Activities in Which the Blind are Separated from the sighted

The accompanying table (Table #7) indicates that there is a low level of positive response for both those receiving and those not receiving services, to segregated activities. As indicated:

- less than one-tenth of the total sample (8%) give a clearly positive response to the separation of the visually handicapped from the sighted
- only one-third of the Service Cases view separated activities positively ("Positive" combined with "Both") This is a little more than one half of the proportion (50%) that regard relationships with other blind persons positively (Table #7)

* "Both" indicates that respondent has had two or more experiences in which one or more was positive and one or more was negative,

~~positively (Table #7)~~

- likewise, almost twice as many Service Cases view separated activities negatively (57%, "Negative" plus "Both") as view them positively (30%, "Positive" plus "Both")
- among those not receiving services, there are no clearly positive responses to the concept of separated activities, but one-fifth of these respondents (20%, "Both") conceive of some positive potentialities; while almost three-quarters (71%, "Negative" combined with "Both") view separated activities negatively
- slightly over one-fifth of the total sample (almost the same for both segments) are non-committal. This response arose out of those who were unwilling or unable to imagine what separated activities might be like; (no service received segment) and among the Service Cases, those who had not yet experienced separated activities (reception pending) or were unable or unwilling to articulate their views.

Table #7

Attitudes of Blind Respondents Toward the Separation of the Visually Handicapped From the Sighted (Segregated Activities)

	TOTAL Sample (N-65)		No Service Received (N-35)		Service Cases (N-30)	
	N	%	N	%	N	%
Positive	5	8	-	-	5	17
Negative	31	48	18	51	13	44
Both	11	17	7	20	4	13
Ambivalent	2	3	1	3	1	3
Non-committal	14	21	7	20	7	23
No information obtained	2	3	2	6	-	-
Total	65	100	35	100	30	100

Regarding relationships with other blind persons, this person, a Service Case, says:

"I don't know anybody else with eye troubles. I do not think I would like to. I like to keep my troubles to myself. I like to forget it. There are lots of people with bum eyes. I saw them up in Veterans, I do not like talking to them, made me feel sorry for them

"I prefer people who see. I feel perfectly normal. I like to joke and sing and be just like anybody else."

Regarding segregated activities, this person, receiving no service, talks about keeping in touch with sighted contacts:

"I'd prefer being with my own friends in the Elks and Masons and I just don't have any time to join other groups. I don't feel all sightless people should be in one club because it doesn't give them a chance to meet other people and get other ideas."

This Service Case observes:

"I don't think it helps - psychologically, it is better - I just would not go for it. I want to be in a normal group so that I can continue to respond normally."

II. Concepts of Blindness and Their Implications

a. What is Blindness?

Only 2 persons (3%) in the sample of blind respondents were as previously mentioned, classified by the New York State Commission for the Blind as "totally blind".* It was not possible within the scope of the Pilot Study to analyze the medical reports of visual acuity for persons included in the sample. In the individual's use of his residual vision, a wide variety of differences in functioning was apparent. Some moved independently not only within their own home, but also in their own neighborhood. Others moved around the city, using various means of transportation. Some read newspaper print with the use of optical aids. Many revealed an ability to care for individual grooming and some were sufficiently competent to take care of their homes, including the cooking. Wherever residual sight was used for one or more aspects of daily living, the respondent clearly indicated the importance of this factor to him. In fact, it is residual vision and its usefulness that appears to motivate many legally blind persons to reject "blindness" as the category into which they fall, and the word "blind" as an appropriate description of their visual loss.

This respondent regards blindness as the absence of any light:

"I do not call myself 'blind'; I would say 'blind' is someone put in darkness."

This respondent finds it difficult to consider himself blind because he reads newspapers:

"I don't know how they (family and friends) think of me. Generally, they don't use the word 'blind' or call me 'blind'. When I bump into things and someone says, 'What's the matter with you, are you blind?', I would say 'almost'. I consider myself visually handicapped but legally, I am blind, but its hard to convince someone you are blind if they see you are reading a paper."

This respondent rejects blindness as a definition of his visual loss because he moves around the city independently:

* (See footnote, page 2, 12% estimated in total population)

"I don't consider myself blind. After all I can find my own way here. Sometimes I walk into people and I have to be very careful. I can't see much to the left or right. I don't know what to call myself."

As discussed in a later chapter, there is considerable confusion over those for whom the specialized agencies exist: those with a visual handicap or only the totally blind? Interviews with ophthalmologists reveal a similar confusion.

b. The Problem with Definitions of Blindness

In discussing their referral practices, a number of ophthalmologists commented on the frequently-discussed problem* of determining to what extent a visually handicapped person needs rehabilitation services, and if so, what type. Two ophthalmologists make these observations:

"But you know another question comes up all the time. You know there is such a thing as an individual determination of blindness. By that I mean, 'blindness' is a different thing for different people. It really depends in many ways on the individual himself and how he experiences or interprets blindness. Individuals react quite differently to various degrees of loss of vision.

"What is 'blindness'? There are five different definitions that I know of and perhaps there are many more. There are the definitions by: 1) the Federal government; 2) by the state in which you live; 3) by various insurance companies; 4) by the Workmen's Compensation law; and 5) the so-called 'legal' definition. So you see that 'blindness' is often what a person or authority thinks it is; it isn't some absolute."

"I have a patient -- a little old lady -- she had always helped in his (husband's) office and she wanted to continue doing so. She has 20/200 vision. And she can read the print I showed you, with optical aids. Should I tell her she is 'blind'? I can't describe her as 'blind', I don't believe it, no matter what the legal definition is. In other words, in your approach to 'blindness' you have to be practical as well as scientific. No two human beings are the same -- and with visual loss it is the same thing. What is 'blindness' for one person is not for another, and in your approach to the patient and his needs you have to be guided by what is possible, practical, and what is suited to the individual need. If you generalize, you just don't serve the patient as well as you should. You cannot throw all persons with the same degree of visual loss into the same hopper. It can't be done without harm to the patient."

The need for a functional definition of blindness that would be universally applied was emphasized by the heads of the Social Service Departments of hospitals, in their conference with the Pilot Study staff. They stressed that where a patient is affected by other types of handicaps, the

* See Braley, A.E., M.D. "The Problem of the Definition of Blindness" in Proceedings of the Thirty-Fifth Convention of the American Association of Workers for the Blind, Inc., Washington, D.C.

"I don't consider myself blind. After all I can see by my feet.
I know I can't see with my eyes, but I can see with my feet.
I don't know what to tell you."

is... in a... there is... for... only...
The... with... of...

is... of... of... of... of... of...
The... of... of... of... of... of...

The... of... of... of... of... of...
The... of... of... of... of... of...
The... of... of... of... of... of...

The... of... of... of... of... of...
The... of... of... of... of... of...
The... of... of... of... of... of...

The... of... of... of... of... of...
The... of... of... of... of... of...
The... of... of... of... of... of...

The... of... of... of... of... of...
The... of... of... of... of... of...
The... of... of... of... of... of...

The... of... of... of... of... of...
The... of... of... of... of... of...
The... of... of... of... of... of...

The... of... of... of... of... of...
The... of... of... of... of... of...
The... of... of... of... of... of...

medical diagnosis usually indicates the degree of disability, so that those directing his rehabilitation have an authoritative estimate of the level of his functioning. This is not true for the "legally" blind which creates a great deal of emotion, misunderstanding and serves to obscure the blind patients' potentialities for rehabilitation.*

c. How the Legally Blind View the "Blind"

The interviews with partially sighted blind respondents reveal insistence on the presence of residual vision; refusal to use the term "blind"; rejection of segregated blind relationships and activities. This suggests that they are trying to avoid the stigma attached to blindness, which they -- as well as the outside world -- tend to impose upon themselves. In other words, it would appear that a large number of respondents reject steps in the direction of rehabilitation services because they would then be identified with a group which society has pushed into a marginal role; they would then be the objects of those same negative characterizations which they -- even at this moment in their lives -- simultaneously apply to blind people and to blindness which they seek to escape themselves. This involves them in a conflict having both positive and negative implications.

One of the best ways to observe the stigma attached to the blind, is to note what the legally blind respondents in the sample have to say about blindness and blind persons:

1. Blindness Implies "Helplessness" and "Dependency"

A person not receiving service and one who is a service case says:

"As long as I am able to get around, I'm OK. I'm not like those people who live in that house for the blind on the corner. They cant see, they're helpless and dependent - I don't like to be around them because they just sit around and do nothing and feel sorry for themselves. That's what they all do at those agencies for the blind. I've never been to one but I can imagine and I'm not interested in any service they have."

"No, I don't consider myself blind either. If I have to be led by the hand or am afraid, then I'd consider myself blind."

* In a Pilot Study of Visual Impairment, American Foundation for the Blind, New York, N.Y. page 3, Eric Josephson, Principal Investigator, points out: "Visual impairment is open to varying clinical, legal and functional or behavioral definitions; ... However, blindness as defined by law is arbitrary in the sense that it includes some persons who appear to function nearly as well as 'normally' sighted persons and excludes others who are severely limited in physical mobility and activity because of trouble seeing ... Defining 'severe visual impairment' as inability to read ordinary newspaper print even with glasses, the Health Survey reports nearly a million 'severely impaired persons'."

2. The Blind are to be "Pitied"

A man who did not respond to the agency's offer of services reacted as follows:

"When you look at other blind people, you realize you're better off. But it's no good for me -- it breaks me up. Maybe I'd get used to it after a while."

3. Blind People are "Miserable" and "Unhappy"

This person, a Service Case, is the recipient of a talking book machine but will have no other contact with a specialized agency for the blind:

"I get a little fed up with hypochondriacs. I do not even like to talk about my handicap. Misery loves company. I do not happen to be in that category. Perhaps I am wrong - I do not know. I do not like such company."

A woman who is receiving major services from a specialized agency feels:

"Maybe they think they could be better understood, being between the same types of people. I don't think so, all those poor people suffering. I don't like to be with people who fall all over themselves and can't get about."

III. The Struggle For Normality

a. Objective Recognition of the Stigma

In interviewing blind respondents, the interviewing staff did not probe specifically for their reactions to the stigma attached to blindness as they experience it in their daily lives. In spite of this, however, approximately one fourth of the respondents made spontaneous observations about the feelings and actions of the sighted toward the blind. In most instances, these were made by persons who are Service Cases. This appears to stem from the higher socio-economic status which characterizes the Service Cases and from the fact that in general they are younger, as much as from any conditioning experience within the specialized agency. This group as a whole are more articulate, appear to objectify more readily, and bring more intellectual and emotional energy to bear on their problems associated with their visual loss.

The psychological response to blindness among these respondents contrasts sharply with that of those in the previous section, who, consciously or unconsciously apply to themselves the negative qualities which society attributes to blindness.

Below are a few typical comments. This blind respondent, a Service Case, notes the association with "disease" which his blindness represents to a relative:

"One of the most hurting things that happened to me was when my sister-in-law whom I helped when she first got married, jumped away from me when I touched her, just like I had a contagious

It was not until the early part of the century that the

idea of a nation as a group of people living together

THE BIRTH OF THE NATION

The nation is a group of people living together

It is a group of people living together

A nation is a group of people living together

The nation is a group of people living together

THE BIRTH OF THE NATION

The nation is a group of people living together

In the early part of the century, the idea of a nation

The nation is a group of people living together

The nation is a group of people living together

The nation is a group of people living together

disease. This hurt me deep down. My wife said to forget it that she was just ignorant, but the fact that a loved one can turn away from you like you are an animal hurts you way down."

This Service Case notes that to others, blindness implies a deterioration of mental faculties and stupidity:

"My wife is the closest person to me. It is not always satisfactory. She cuts me short when I'm speaking and acts as if my blindness has affected my intelligence. Yet before I was blind she knew that she was nothing intellectually, compared to me. Now that I am dependent on her she treats me like I am a child. I want to scream sometimes, but I try not to. I have learned to control these feelings a great deal."

Another Service Case notes the unpleasantness with which he feels most blind persons are received:

"Most people want to be with other people who have the same problem. They stick together to work on problems together. When you go with a group of people who can see, you get in the way. People don't want to go out of their way to help very often. People don't have time for caring about problems that are not theirs. I guess everybody's got his own grief to bear. But some can be a big help. Some can be real nice. They can help you out in a way that makes you feel real good. Not many though."

Social rejection by the sighted is noted by this Service Case:

"Sighted people don't always want to let people in, even if the blind don't want to be separated. They may be pushed off by those with sight. They are afraid of the blind - afraid they, too, will become blind - they would rather not see the blind. I am not saying this about other people alone. I felt the same way - I was frightened of the blind - I only thought of them as beggars. I know now that it is different but I wish the agencies could get the beggars out of the subways -there is no reason for it with all the help that is available, I know better now."

b. An Interest in People Not Blindness

A minority of the blind respondents in the sample do give evidence that they are able to reject both the external application of the stigma attached to blindness and an internal imposition of the stigma on themselves. These are the persons who feel that they choose their personal relationships on the basis of congeniality and/or that it does not matter whether their associates are blind or sighted.

These persons, receiving no service, express their feelings about congeniality:

"It makes no difference to me, I feel just as comfortable with a group that had visual problems as I do with a group that doesn't have them. If they are friendly people that's all that matters to me."

"They're both the same. It wouldn't make any difference to me, to be perfectly frank. That's a hard question."

...the fact that the ...
...the fact that the ...
...the fact that the ...

...the fact that the ...

...the fact that the ...
...the fact that the ...
...the fact that the ...

...the fact that the ...

...the fact that the ...
...the fact that the ...
...the fact that the ...

...the fact that the ...

...the fact that the ...
...the fact that the ...
...the fact that the ...

...the fact that the ...

...the fact that the ...
...the fact that the ...
...the fact that the ...

...the fact that the ...

...the fact that the ...
...the fact that the ...
...the fact that the ...

...the fact that the ...

The following person, a Service Case indicates similar feelings: that he is interested in people not blindness:

"I have no preference for being with either kind of person. I don't see how anyone could. It depends who is in each group -- I can't generalize."

c. The Need for Independence and Its Implications for Accepting or Seeking Rehabilitation Services

Initial hypothesis of the Pilot Study was that the dependency relationships induced by blindness could serve as a barrier to the acceptance or seeking of rehabilitation services.

Investigation of this area of the blind person's feelings, attitudes, activities and relationships with family, friends, and influential others consisted of two parts:

- 1) specific probes put to him by members of the interviewing staff as follows:

A lot of people with eye trouble to whom we have spoken say that they feel like a burden to their family. Yet others complain, and say they are expected to do too much and that they should be waited on now that their eyesight is giving them so much trouble. How do you feel about these points of view?

To what extent do you feel people with eye trouble should continue doing things for themselves?

In general, how would you say your family feels about your doing things for yourself? What are some of the things they like you to do for yourself? How do you feel about this? What are some of the things they would prefer to do for you? What are your feelings about this?

- 2) An analysis by the Pilot Study staff of respondents' reports regarding the extent to which they do things for themselves in their daily activities: orientation and mobility; reading; self-care; home care; employment; recreational and social activities; in their relationships with friends, families and organizations in the community.

An analysis of the accompanying table (Table #8) indicates that:

-- three-quarters of both segments in the sample population, the service cases and those not receiving service, have positive attitudes towards "doing things for themselves"

-- there is a very low level of "No information" in this area.

On Table #9, it is noted that:

-- as expressed by blind respondents, family members are less favorable (34%) than the blind respondents are toward the respondents' own independence

-- there is a high level of "No information" in the blind persons' responses to family members' attitudes and actions, rendering these findings less insightful than those in Table #8

Table #8

Attitudes of Blind Respondents Toward Doing Things for Themselves

	TOTAL Sample (N-65)		No Service Received (N-35)		Service Cases (N-30)	
	N	%	N	%	N	%
Positive	48	74	26	74	22	73
Negative	8	12	6	17	2	7
Both	3	5	-	-	3	10
Ambivalent	-	-	-	-	-	-
Non-committal	2	3	1	3	1	3
No information obtained	4	6	2	6	2	7
Total	65	100	35	100	30	100

Table #9

Attitudes of Family Members Toward Respondent Doing Things for Himself
(As Expressed by Blind Respondents)

Positive	22	34	12	34	10	33
Negative	10	15	4	12	6	20
Both	2	3	-	-	2	7
Ambivalent	-	-	-	-	-	-
Non-committal	1	2	1	3	-	-
No information obtained	30	46	18	51	12	40
Total	65	100	35	100	30	100

A woman whose service status is pending reports:

"I think people should do things for themselves and they shouldn't get helpless. You should do the best you can. (no family) I prepare all my own meals. I likes to do all my own cooking and eat my own food. -- I don't like to eat out or what others prepares. -- I go outside most time alone -- at crossings I waits till other people go and then I know it's OK. I would like to learn how to use a cane for travel. I would like to find some kind of work that I can do. I would like to get off Welfare and earn my own way if I could. I never knew there was anything for people like me to do."

Illustrative of this respondent's feeling that her family tried to limit her independence is her observation:

"Deep down, I feel this way, (that she's a burden to her family). But they will try to be very helpful.-- too helpful. Especially my sister. She's afraid I'll hurt myself, and she always tries to help me. She can't overcome her fear I'll get hurt. I think it's very good that people should try to do things for themselves. After all, what about the people that live at home?"

"They don't tell me what to do. In fact, they try to do everything for me. But I go ahead and do a lot of things for myself. I can make my bed, wash dishes, dust, etc. The only thing I don't try to do is vacuum the floor. I'm afraid I'll hit everything. I would prefer doing practically everything by myself. But they have to see for themselves first that I can do it."

Efforts were made by the Pilot Study staff to establish internal validity within each interview: to determine whether his report of his independence coincides with other responses having significant relationships to it. It is the considered opinion of the Pilot Study staff that a large number of respondents do the things for themselves that they report; that many resent the "over-helpfulness" of family and friends. Moreover, the finding that three-quarters of the blind respondents indicate a desire for independence is, in terms of the over-all analysis, possibly further evidence of basic resistance to the social stigma attached to blindness.

In determining the effects of the findings upon the initial hypothesis, that dependency relationships may be a major cause of delay in receiving rehabilitation services, it would be necessary, in any further research, to determine: 1) valid criteria for independence; 2) the effects of many variables (age; socio-economic status; condition of blind person's health; level of independence prior to onset of blindness, etc.) upon independence.

SECTION D

WHAT IS THE EFFECT OF GRADUAL PROGRESSION IN THE LOSS OF SIGHT?

I. Gradual Progression Related to Age

Gradual loss of sight may be a concomitant in the process of aging, along with other losses in physical functioning. A slowing down of activities, a lessening of interests is often accepted as a normal pattern of 'growing old'. The passive acceptance of lessened ability of physical function was found to be a significant factor in not seeking services to substitute or replace those skills lost due to diminution of sight. This was expressed by several blind respondents:

"I don't think I should be trained. I'm satisfied the way I am, I've made the best. I'm too old to be trained, don't want it. It's too late to start something new. -- I think they're good (services) for people who're young enough to participate."

"I wouldn't (be interested in services) -- I'm through with everything. I'm done for. This takes the life out of you. It is the worst thing in the world. When your eyesight goes, you're finished. I'm near 70. I don't go for that stuff. I can't learn to travel. I don't care anymore. What can I do?"

The tragedy of such passive acceptance lies in the unnecessary loss of many of these skills which would add immeasurably to the comfort of the blind person and his family, his sense of usefulness and to the enrichment of his life. For example, a continuation of his ability to take care of his personal needs without assistance, his contribution to household management and of many of his life-time social, recreational and community activities.

Although apathy, lack of motivation and resistance to new experiences characterized the attitude of a number of the aging, in some instances there was an indication that it was their children who were depriving their parents by superimposing upon them their own attitude of passive acceptance. Also, when severe loss of sight is combined with old age, both the "over-protection" by some and the "shunting aside" by others appears to be reinforced. The majority of blind persons are in the older age brackets and are often dependent on their families in many ways because of their age. It would be valuable therefore, to explore the best means of interpreting to both the blind person and to their families those activities which need not inappropriately be curtailed or given up because of age or blindness per se.

II. Gradual Progression Related to Disease and/or Age

Gradual progression in the loss of sight may occur not only in relation to age but also in relation to disease at any age and at varying tempos. It may, for example, be directly related to the progress of other diseases such as diabetes.

The following Table #10, gives the principal causes of blindness for the study sample:

Table #10

Principal Causes of Blindness as Classified by the New York State Commission
for the Blind

	TOTAL Sample (N-65)		No Service Received (N-35)		Service Cases (N-30)			
	N	%	N	%	N	%		
Diabetic Retinopathy	13	20	8	23	5	16.5		
Glaucoma	12	18	9	26	3	10		
Cataract	4	6	4	11	-	-		
Myopia	5	8.6	2	6	3	10		
Macular Degeneration	4	6	2	6	2	6.5		
Other Retinal Affections	11	17	5	14	6	20		
All other causes	16	24.4	5	14	11	37		
Total 65		100	35		100	30		100

Where loss of sight is so gradual that the transition from the non-blind to the legally blind category is not sharply apparent, not only are physical adjustments more readily achieved but in the opinion of the medical social workers, who participated in the study, it is psychologically easier to deny the severity of the loss. A blind respondent states:

"Oh, it was a shock at first, of course. When somebody tells you you're going to be going blind or nearly blind it's like a punch in the stomach. But this disease doesn't hit suddenly and it doesn't leave you completely blind. I can still see in the daytime and read with a magnifying glass. Night time is the only time it's really bad. Then it's terrible. I can't see at all and I don't go out. Over the years my eyes have gotten steadily worse. It's a very gradual process. You just get acclimated to it after a while and you sort of live your life in spite of it. The guy I really feel sorry for is the one who goes blind all of a sudden. That must really be hell. You wouldn't have any time to get used to it. I just kept on going, working. You don't lose everything. I don't feel sorry for myself and I don't ask for any sympathy."

An ophthalmologist states:

"It (the time gap) is generally that the process of loss of vision is a slow and gradual one. We never know at what point the person is going to become blind. The man that I mentioned works and he is not blind because he has enough vision to work. In other words, he doesn't function as a blind person."

and another states:

"Another reason for the gap, I think, is this: when a person loses vision rapidly, and there is a condition or state of shock -- and the person is suddenly blind -- then he yells louder. He gets to rehabilitation sooner. When the onset is gradual, the body has a chance to adjust to the gradual loss of vision more slowly, then the person finds himself far more capable

Percentages of Persons Classified by Sex for Each Category

Category	Total		No. Persons		Sex
	(18-27)	(28-37)	(18-27)	(28-37)	
	1	2	3	4	
All other cases	26	25.2	12	13	12
Other Federal Employees	11	11	11	11	11
Health Department	1	1	1	1	1
Police	2	2.5	2	2	2
Customs	4	4	4	4	4
Glenn County	15	16	15	16	15
Industrial Hygiene	13	20	13	20	13

These data of age in no way indicate the transmission of the disease. The age of the person is not a factor in the spread of the disease. The age of the person is not a factor in the spread of the disease. The age of the person is not a factor in the spread of the disease.

It is not a matter of fact, of course, that anyone who is infected with the disease is going to die. It is a matter of fact that anyone who is infected with the disease is going to die. It is a matter of fact that anyone who is infected with the disease is going to die. It is a matter of fact that anyone who is infected with the disease is going to die.

It is not a matter of fact, of course, that anyone who is infected with the disease is going to die. It is a matter of fact that anyone who is infected with the disease is going to die. It is a matter of fact that anyone who is infected with the disease is going to die. It is a matter of fact that anyone who is infected with the disease is going to die.

It is not a matter of fact, of course, that anyone who is infected with the disease is going to die. It is a matter of fact that anyone who is infected with the disease is going to die. It is a matter of fact that anyone who is infected with the disease is going to die. It is a matter of fact that anyone who is infected with the disease is going to die.

of handling himself, and he tends to feel he doesn't need rehabilitation services."

III. Accomodation

With respect to the adjustment mentioned by the blind respondent and the ophthalmologist above, it was found that the accomodation achieved by many of the blind persons interviewed was described as being satisfactory to them. For example,

"I don't consider myself blind - don't think other people do - I've worn glasses since I was fifty, and these are just stronger and different. My grandchildren just know I can't see as good as I used to. -- I've adapted myself and I can do the things I want, so I'm not so concerned about some of the things I can't do."

They often referred with pride to the things they had learned to do for themselves - mostly getting about without help - keeping their homes clean - cooking for themselves. Their frustration was expressed around inability to drive a car - travel distances - find a job. The level of accomodation achieved was usually within an extremely narrow environment and through a trial and error method, with marked familial dependency. For the legally blind person to do as much as possible for himself and for the person with useful sight to continue to function as a sighted person as long as it is feasible, obviously has positive values, but for the blind person to accept a low level of functioning or go through a long, tedious and frequently dangerous period of trial and error when, with rehabilitation help, he could attain a more comfortable level of functioning obviously has negative values. An accomodation at a low level - a sort of equilibrium, or at an inactive level of functioning, was particularly characteristic of the No Service Received segment of the sample.

IV. Sudden Onset

It was hypothesized that persons for whom onset of blindness was sudden would be more likely to seek rehabilitation services to cope with the demands that unexpected loss of sight brings. The following Table #11 bears out this hypothesis. Of the 25 persons for whom onset of blindness was sudden, 60% were in the Service segment. Of the 25 for whom there was gradual progression, only 36% were in the Service segment.

Table #11

Progression of Eye Condition as Reported by Blind Respondent

	TOTAL Sample (N-65)		No Service Received (N-35)		Service Cases (N-30)	
	N	%	N	%	N	%
Sudden Onset	25	38	10	28	15	50
Gradual Progression	25	38	16	46	9	30
Congenital	9	14	7	20	2	7
Information not obtained	6	10	2	6	4	13
Total	65	100	35	100	30	100

of medical history, and in order to find the cause of the disease.

III. Discussion

With respect to the adjustment mechanism of the blind response, it is clear that the adjustment mechanism is very sensitive to the level of the response. The level of the response is determined by the level of the response.

The level of the response is determined by the level of the response. The level of the response is determined by the level of the response. The level of the response is determined by the level of the response.

The level of the response is determined by the level of the response. The level of the response is determined by the level of the response. The level of the response is determined by the level of the response. The level of the response is determined by the level of the response.

IV. References

If you wish to know more about the level of the response, you should consult the following references. The level of the response is determined by the level of the response.

Table 1

Progression of the level of the response in blind response

Level of response	No. of responses		Total	
	Correct	Incorrect	Correct	Incorrect
1	10	10	20	0
2	15	15	30	0
3	20	20	40	0
4	25	25	50	0
5	30	30	60	0
6	35	35	70	0
7	40	40	80	0
8	45	45	90	0
9	50	50	100	0
10	55	55	110	0
11	60	60	120	0
12	65	65	130	0
13	70	70	140	0
14	75	75	150	0
15	80	80	160	0
16	85	85	170	0
17	90	90	180	0
18	95	95	190	0
19	100	100	200	0
20	105	105	210	0
21	110	110	220	0
22	115	115	230	0
23	120	120	240	0
24	125	125	250	0
25	130	130	260	0
26	135	135	270	0
27	140	140	280	0
28	145	145	290	0
29	150	150	300	0
30	155	155	310	0
31	160	160	320	0
32	165	165	330	0
33	170	170	340	0
34	175	175	350	0
35	180	180	360	0
36	185	185	370	0
37	190	190	380	0
38	195	195	390	0
39	200	200	400	0
40	205	205	410	0
41	210	210	420	0
42	215	215	430	0
43	220	220	440	0
44	225	225	450	0
45	230	230	460	0
46	235	235	470	0
47	240	240	480	0
48	245	245	490	0
49	250	250	500	0
50	255	255	510	0
51	260	260	520	0
52	265	265	530	0
53	270	270	540	0
54	275	275	550	0
55	280	280	560	0
56	285	285	570	0
57	290	290	580	0
58	295	295	590	0
59	300	300	600	0
60	305	305	610	0
61	310	310	620	0
62	315	315	630	0
63	320	320	640	0
64	325	325	650	0
65	330	330	660	0
66	335	335	670	0
67	340	340	680	0
68	345	345	690	0
69	350	350	700	0
70	355	355	710	0
71	360	360	720	0
72	365	365	730	0
73	370	370	740	0
74	375	375	750	0
75	380	380	760	0
76	385	385	770	0
77	390	390	780	0
78	395	395	790	0
79	400	400	800	0
80	405	405	810	0
81	410	410	820	0
82	415	415	830	0
83	420	420	840	0
84	425	425	850	0
85	430	430	860	0
86	435	435	870	0
87	440	440	880	0
88	445	445	890	0
89	450	450	900	0
90	455	455	910	0
91	460	460	920	0
92	465	465	930	0
93	470	470	940	0
94	475	475	950	0
95	480	480	960	0
96	485	485	970	0
97	490	490	980	0
98	495	495	990	0
99	500	500	1000	0

When the time gap (Table #1, Page 12) was examined for the Service and No Service Received segments of the sample in terms of suddenness of onset it was found that suddenness of onset is apparently a motivating factor in the early acceptance of service. For example, for the Service Cases 37% of those who experienced a gap of no more than two years between onset and offer of services report "sudden" onset. Among the No Service Received group, within the same two year period, only 9% report sudden onset.

Table #12

Comparison of Time Gap and Progression of Eye Condition

Time Gap Between Development of Serious Eye Condition and Offer of Specialized Services

<u>Service Cases</u> (N-30)	<u>Less than 6</u>		<u>6-11 Mos.</u>		<u>1-2 yrs.</u>		<u>3-10 yrs.</u>		<u>Over 10 yrs.</u>		<u>No Info.</u>		<u>Total</u>	
	N	%*	N	%*	N	%*	N	%*	N	%*	N	%*	N	%
Sudden	5	17	1	3	5	17	4	13	-	-	-	-	15	50
Gradual	2	7	1	3	1	3	4	13	1	3	-	-	9	30
Congenital	-	-	-	-	-	-	1	3	1	3	-	-	2	7
No Information	-	-	-	-	-	-	2	7	-	-	2	7	4	13
													30	100

No Service Received
(N-35)

Sudden	1	3	-	-	2	6	5	14	2	6	-	-	10	29
Gradual	-	-	4	10	3	8	8	23	1	3	-	-	16	45
Congenital	1	3	1	3	-	-	1	3	3	8	1	3	7	20
No Information	-	-	-	-	-	-	-	-	-	-	2	6	2	6
													35	100

Conversely, there are more persons (26%) who had experienced a gap of more than two years and who had reported "gradual" onset are in the No Service Received group than are found in the Service group (16%) who had also reported "gradual" onset.

The analysis of the No Service Received cases also shows that in addition to the heavy weighting of gradual progression, they are generally older, have lower incomes and are at a lower educational level than the Service Cases. Further analysis is needed to have a better understanding of the interrelatedness of these factors.

V. Research Needed

The implications of the above suggests the importance of the timing of rehabilitation referrals by ophthalmologists and indicates further research on how best to reach the "gradual progression" segment of the blind population is essential.

* Due to rounding, the percentages in the rows are somewhat less than the percentages in the Total column.

When the first year (1961) was completed for the Service and the Service Bureau of the sample in terms of volume of work it was found that volume of work is generally a decreasing factor in the early months of service. The sample for the Service Bureau 1961 of work was reported a gap of 10 days between the first and second year of service. The sample for the Service Bureau 1962 was reported a gap of 10 days between the first and second year of service. The sample for the Service Bureau 1963 was reported a gap of 10 days between the first and second year of service.

Table IV

Comparison of Two Year and Three Year Periods of the Service

The following table compares the Service Bureau 1961 and 1962 in terms of volume of work.

Service Bureau	1961		1962		1963		1964		1965	
	Vol.	Cost								
General	100	100	100	100	100	100	100	100	100	100
Administrative	100	100	100	100	100	100	100	100	100	100
Technical	100	100	100	100	100	100	100	100	100	100
Professional	100	100	100	100	100	100	100	100	100	100
Other	100	100	100	100	100	100	100	100	100	100
Total	100									

Generally, there are two reasons (1) why the volume of work is reported a gap of 10 days between the first and second year of service. The sample for the Service Bureau 1961 of work was reported a gap of 10 days between the first and second year of service. The sample for the Service Bureau 1962 was reported a gap of 10 days between the first and second year of service.

The analysis of the Service Bureau 1961 and 1962 shows that in addition to the early volume of work, the volume of work is generally higher than the volume of work in the early months of service. The sample for the Service Bureau 1961 of work was reported a gap of 10 days between the first and second year of service. The sample for the Service Bureau 1962 was reported a gap of 10 days between the first and second year of service.

7. Summary

The analysis of the Service Bureau 1961 and 1962 shows that in addition to the early volume of work, the volume of work is generally higher than the volume of work in the early months of service. The sample for the Service Bureau 1961 of work was reported a gap of 10 days between the first and second year of service. The sample for the Service Bureau 1962 was reported a gap of 10 days between the first and second year of service.

* In the Service, the percentage in the two year period is less than the percentage in the three year period.

SECTION E

FALSE HOPE, A DETERRENT IN REHABILITATION?

What the Ophthalmologists Say

The ophthalmologists interviewed had differing opinions about whether hope for recovery should always be left with the patient. This was in sharp contrast to their unanimous opinion that the patient should be informed about his eye condition and that it was the doctor's responsibility to inform him. Opinions also differed as to the timing of giving the information to the patient. The following quotations illustrate these differences: --- (underlining added)

"I always inform him. -- I am optimistic with him. I tell him there is always a chance, there is something which may help him. -- I never give the patient a bad outlook. -- I have a man who is 48 who was shot in the temple and he became blind but I still gave him hope. For example, I tell him that there may be new operations in the future. If you don't give them hope, if you're not optimistic, they find life hopeless. I always give hope when they are younger because they have a long life ahead of them."

"The best time? It differs from person to person. I tend to give hope rather than blast them with the truth. In most of the cases I (general practitioner) see where irreversible blindness occurs, the ophthalmologist has this responsibility (of informing the patient)."

"At a point where it is obvious that long-range progress is a poor one, I would tell the patient and where the patient expresses some concern. Sometimes, people do not ask and unless they ask, I do not tell them. I guess you could conclude that at the time the vision has become a disability, I would so inform them."

"I would inform individuals who are sufficiently stable from a personality viewpoint -- they should be told. They would want to know. I have found that people resent being given false hopes -- they can deal with problems more realistically."

"Yes, I inform all clients about their condition and only if the client is a psychiatric case would I not inform him. I think every person should be informed of the nature of his condition. This is the only way you can expect him to take the proper steps for his future. -- If I feel that the patient's ocular condition is progressive, that is, deteriorating. I would inform him in a gentle way and at an early stage so that he would be gradually able to adjust to the situation."

"The main reasons (for the time gap between onset of blindness and rehabilitation services) as I see them are:

- 1st: the doctors' reluctance to tell patients they are legally blind, that they are visually handicapped and probably going to stay that way, in cases where this can be determined.
- 2nd: the patients' reluctance to hear this; they just will not hear it, they start running away from it. At least five or six out of ten won't accept, but the ophthalmologists lead even them in non-acceptance,"

THE HISTORY OF THE UNITED STATES

and the ...

The ... and ...
The ... and ...
The ... and ...

I ... and ...
I ... and ...
I ... and ...

The ... and ...
The ... and ...
The ... and ...

It ... and ...
It ... and ...
It ... and ...

I ... and ...
I ... and ...
I ... and ...

The ... and ...
The ... and ...
The ... and ...

The ... and ...
The ... and ...
The ... and ...

Another ophthalmologist says:

"the second main reason for the gap is that doctors themselves are reluctant to admit to a patient that he is blind, especially if you have been involved with a patient for a long time. It is very hard to admit that the patient's sight is irrevocably gone."

These comments suggest that the physician is influenced not only by what he considers is best for his patient but also by his own reaction to blindness. A reluctance to admit his patient is blind may relate to his own reaction to the stigma attached to blindness; to a feeling that blindness represents failure in medical skills or knowledge; to an inability to cope with the emotional components of a patient's abandonment of hope; to false hope on his own part and other factors.

The number of doctors in the sample was too small to produce reliable statistical data but it would appear that the New York City doctors interviewed reacted in a manner similar to those in a large representative group of ophthalmologists (180) who were included in a study made in 1958 by Professor Samuel Finestone and Dr. Sonia Gold.* They reported, "Some 63% did not believe hope should be left, while 31% (the remainder not answering) adhered to the belief that hope for recovery should always be left." A smaller group of ophthalmologists in this study (18) selected for their own experience and interest in rehabilitation programs were, however, heavily of the opinion (14 out of 18), that the practice of leaving hope, even though an established condition of irreversible blindness exists, "was not wise in that rehabilitation efforts by the patient were impeded."

What the Medical Social Workers Say

The discussion of the Committee of Medical Social Workers about the effect of false hope revealed the importance they attach to it. Based on their experience they commented: 1) that doctors seem to feel guilty over the patient's loss of sight, feeling that they have "let the patient down" and they are therefore reluctant to think of what rehabilitation implies; 2) some doctors have to be encouraged to explain the full details of the eye condition to the patient and 3) doctors are less likely to inform the uneducated than the educated. They have found too, doctors being unfair to patients by offering hope, a chance of sight, when it wasn't really true, with a comment, "How can I deprive him of hope?" It was also suggested that the clinic setting tends to encourage on-going clinic visits which may in turn lead to a false interpretation by the patient of a possibility of improvement in sight. They felt, as did one of the ophthalmologists quoted above, even when the doctor does give complete and adequate information the patient often "hears what he wants to hear" - one discussion may not be enough, the patient may need several discussions, going over the explanation again and again. In their experience, patients with serious disabilities tend to protect themselves from anxiety by excluding information given from their awareness.

What the Blind Respondents Say

There are divergent opinions among the blind respondents, as there are among the ophthalmologists, about whether they wish to be left with hope "at any cost".

* Finestone, Samuel, and Dr. Sonia Gold, The Role of the Ophthalmologist in the Rehabilitation of Blind Patients, The American Foundation for the Blind, New York, N.Y., and the Seeing Eye, Morristown, N.J., 1959, Page 55.

The opinions ranged from expressions of deep gratitude for having been promptly and adequately informed to complete rejection of attempted explanations. There were also expressions of resentment about not being told and indications of irresponsible "shopping around" in order to get a more favorable diagnosis (as well as planful seeking of several medical opinions for confirmation or for the most expert medical help available). There were those who were not convinced about the diagnosis and those who did not wish to be convinced. Although no statistical analysis is possible since the interview questions were not specifically directed to elicit the extent of false hope for improvement, the response of a large majority implied that they very much wished to know the exact nature of their eye condition.

Typical responses in relation to "false hope" were: - (underlining added)

"I went back to the first doctor I had seen and asked for his opinion. He said he hated to tell me this because he had been hopeful something could be done, but now he told me nothing could be done. He made me come and come, but all the time he was afraid to tell me the truth."

"One thing I have against them, except for the doctor at New York Hospital, is that they didn't tell me what to expect. As a result I was living in hopes and expectations. (WOULD YOU HAVE LIKED TO KNOW?) "To tell me the truth, I would be resigned to it. I asked if anything could be done - 'Oh yes', but there was nothing that could be done. The doctor at New York Hospital told me the truth, stopped the medication. I was then resigned. The other anxiety was terrific."

"About a week later I went to the doctor - the doctor never told me what was wrong. I asked him over and over, he would never tell me. I still work 14 hours a day on my feet. My doctor is an eye specialist - he never would tell me if I was going to go completely blind - you must know or you wouldn't send me the letter."

(DID YOU TELL YOUR DOCTOR ABOUT GOING TO THE HOSPITAL?) "My wife told him, I didn't want to. I explained that it wasn't because I had no faith in him, but when you hear about somebody who's going to help you, you go, no matter where it is."

"The first one was an eye specialist, members of the family went to him, they were satisfied. He said it wasn't too serious and I felt good about it but then it got worse and he said not to worry about it. He probably thought in terms of my going blind that I shouldn't worry but I couldn't see good then. Maybe he was talking from his point of view."

"They (family) think I have a faith it (eyesight) is going to come back a little. I have a faith. My family is the same. When I lay down, I rest a lot, and when I lay down I feel I am not blind. But when I wake up I feel blind. I always feel this way, if God wants to He'll give it back, if He wants to." (SO YOU DON'T CONSIDER YOURSELF BLIND?) "No, not blind. I feel it's going to come back."

"I don't think of myself as being blind like some people who use dogs to lead them or use canes for aid. I just think I have bad eyes which will get better eventually."

"From his own experience with blind people, he shows how the tragedy of new blindness is only deepened and prolonged by encouraging the patient to escape from facing the reality that is upon him. He shows that it is false kindness to try to spare the person the shock and grief. These must be undergone before there can be rehabilitation.*"

Since there is such widespread evidence that false hope of improvement is an important block to rehabilitation and at the same time there is strong evidence that a significant number of ophthalmologists believe that hope for recovery should always be left with a patient even though irreversible blindness exists, this problem also represents another area in which more careful study and further research is needed.

*Carroll, Rev. Thomas J., Blindness, Little, Brown & Co., Boston, Mass., 1961
Page 12.

For his own experiments with blind people, he shows how the frequency of the
disturbance is only dependent on the frequency of the disturbance in the patient's
own body. The results show that it is not the frequency of the disturbance in the
patient's own body that is important, but the frequency of the disturbance in the
patient's own body. These results are in agreement with the results of the
other experiments.

Since there is such a strong evidence that the frequency of the disturbance is an
important factor in the disturbance and at the same time there is strong evidence
that a significant number of patients believe that the frequency of the disturbance
should always be left with a patient even though irreversible blindness exists,
this paper also represents another step in which more careful study and further
research is needed.

SECTION F

HOW MUCH IS KNOWN ABOUT SPECIALIZED AGENCIES AND THEIR SERVICES ?

In order to determine the awareness of blind persons of the existence of specialized agencies and the services available, the respondent was asked to describe the problems confronting him in his daily life in relation to his visual loss. Interviewers were asked to probe for: a) the respondent's level of interest in services related to each problem described; b) the respondent's knowledge of existing community agencies; c) where and how he found out about existing agencies.

At the conclusion of this research area, the field staff members were again asked to probe for what the respondent knew about existing agencies and available services. In the final section of the interviewing schedule, respondents were asked a third time to recall anything they might have heard about agencies and rehabilitation services which they might not have mentioned earlier in the interview.

I. Low Level of Awareness

The findings indicate that of those persons who had received no services only 3% are "Very Much" and 77% are "Somewhat" aware of specialized agencies; similarly, only 11% are "Very Much" and 55% are "Somewhat" aware of the services they offer. (Table #14)

Table #14

(A) Extent of Blind Respondents' Awareness of Specialized Agencies for the Blind

	<u>No Service Received</u>	
	(N-35)	
	N	%
Very much	1	3
Somewhat	27	77
Not at all	6	17
No information	1	3
<hr/>		
Total	35	100

(B) Extent of Blind Respondents' Awareness of Specialized Agency Services

Very much	4	11
Somewhat	19	55
Not at all	11	31
No information	1	3
<hr/>		
Total	35	100

The category "Somewhat" needs definition: all persons to whom the name of an agency was remotely familiar, or who had "heard of" one type of rehabilitation service (such as braille, talking book machines, mobility training, guide dogs, etc.) fell into the category of "Somewhat". "Very Slight" awareness would characterize approximately 75% of those in the "Somewhat" category, but it proved impossible in view of the limited awareness of the respondents to develop firm criteria for a scale other than the one used.

Varied sources of information were cited. Seven respondents indicated that ophthalmologists made rehabilitation suggestions to them (See Table #23 (A) and (B), Section I, page 70), while seven others said that their sole source of information was a letter received from one of the specialized agencies seeking a contribution. Two persons had contacts with Social Service departments of hospitals; the Department of Welfare and the Veterans Administration had contributed to the awareness of two respondents each; radio and TV spot announcements were recalled as the source of their information by six respondents; and relatives or friends of three respondents had spoken generally of specialized agencies or services. Scattered in between this minimal clustering of responses were two persons aware of the New York State Commission for the Blind (one who had received and discarded a letter; the other had visited the office and had a good conception of what was available, but chose to reject services). This paucity of awareness is a further illustration of the non-effectiveness of the Commission's form letter.

Whatever the source of information, the interviews revealed that the knowledge of available services and of places where they may be sought is fragmentary and vague, and only a few of those not receiving service give evidence of interest.

This is what the respondents have to say:

Somewhat Aware

"Mrs. F., a social worker at the hospital, called the Z agency on my behalf. The people from the agency are very nice. A gentleman came over to my house and asked me a lot of questions about everything. I needed help to go to the clinic, I told him. Later they sent me a Mrs. T. She is very nice, too.

"No, I never asked them for anything more than just getting me to the clinic.

(Do you know of any other services the Z agency might have to offer you?)

"I really don't know -- I guess they do more than just sending out volunteer workers, but I never asked them for anything ... I do the best I can without any help ... Never before in my life did I depend upon other people for help. I still try to do the best I can ... (I can see that. But were the various services that the Z agency has to offer, ever explained to you?) "I don't think so ... I can't remember whether they did ... No, I don't believe that they ever did ... (Did you ever have contact with any other agency servicing blind people?) "Yes, once Mrs. F. (hospital social worker) thought I needed a cane, and she called up the X agency to help me with this. Two people came to my house ... One of these was blind himself ... They, too, interviewed me and asked a lot of questions. We agreed to go to a special shop in the city where I could get a rubber-tipped cane. You have to go there yourself, so that they could see whether the cane has the right length. I never got that cane, because these people from the X agency never came back."

- - - - -

Mr. L. has heard that special agencies are; "Nice to go to. They help people forget most of their problems. They are good for socializing and teaching the people many things." Mr. L. heard about these agencies from the doctors and patients at the hospital.

No Awareness

"I can't read the newspaper, so I have no information. Sometimes on the radio I hear information on diabetes or heart, but nothing on the eyes. (SHE RE-ACTED WITH SURPRISE "There are?" WHEN I TOLD HER THAT THERE ARE PLACES THAT HELP PEOPLE WITH SIMILAR PROBLEMS.) I never heard that. The only thing is that the investigator (Welfare Department) sent a doctor when my daughter called them to say that I had eye trouble. I know there are clinics, but I can't go myself."

"To be perfectly frank, I know about the X agency because they come around and leave leaflets. About anything else, I don't know. To be truthful, I don't know anything about these places."

And a blind respondent whose serious eye condition is long standing:

"No, never. I hear nothing about it. And I was not interested because I had no time, and I can't run around. They don't help me. (WHAT AGENCIES DO YOU KNOW ABOUT?) I do not know of any. I never was there. And I don't want it now. I am too old. I get along myself very well. That's too much for me. Nobody has ever talked to me about organizations - no, never, never, never."

It was noted previously that persons in higher socio-economic groupings appear as little aware of specialized agencies and available services as those in lower socio-economic groupings. Inasmuch as only five persons in the No Service Received segment had an education of "Some College" or more, and only six persons report a household income exceeding \$5,000, no definitive findings in this area can be stated. But of these persons, only one appeared to be fairly knowledgeable about the agencies and services available. A more typical response of this group's limited information is this comment by a wealthy respondent, active in a large number of community organizations, indicating what she knows about specialized agencies for the blind:

"I know the X agency is a place where people read to people and a place where blind people make things for a living. That is about all I know about it. "My only contact was with the Low Vision Lens service and I found them very nice. I don't really know what else they do. I had a friend who read to blind people at the X agency. Otherwise, I have had no contact at all."

Whether this lack of information and knowledge is real or apparent is probably subject to further research. Specific aspects of this communications failure are discussed later in this chapter, Section H.

II. Limited Concepts of Rehabilitation

Perhaps the most serious consequences of this communications failure is the limited conception of rehabilitation services held by blind respondents not receiving services. Whatever other factors may act as barriers to seeking service, the level of understanding of these services, as exhibited by the majority in this sample, is such that only the most highly self-motivated individual would be likely to ferret out the information he needs in order to make a decision about seeking and accepting services.

Typical of these limited conceptions are the following comments:

(What do you know of organizations that teach people to read braille?) "No organizations. What is braille?"

(In response to probe on impressions of agencies:) "I heard they say they help, but I don't know what they do."

(Probes on reading) "I read papers and books once in a while. The radio reads to me. Talking books? Never heard of that."

(Probe re knowledge of organizations) "Not personally. Don't know of any. What could they do for me? Me for them?"

A respondent in his early sixties who had attended college, discussed his favorable impressions of an interview he had had. He states; "He (agency worker) wanted to know what he could do for me -- not financially, but what did I like most, what would I like. I never even knew before some of the services he offered me and he was prepared to offer most anything if I was interested."

III. Low Level of Interest in Service

In view of the lack of information about agencies and services, and considering the other factors described in previous chapters, it is not surprising that 65% of those not now receiving service indicate "no interest" in so doing. (Table #15)

Table #15

Extent of Interest Expressed by Blind Respondent in Specialized Services

	TOTAL Sample (N-65)		No Service Received (N-35)		Service Cases (N-30)	
	N	%	N	%	N	%
Very much	18	28	3	9	15	50
Somewhat	20	30	9	26	11	37
Not at all	26	40	23	65	3	10*
No information	1	2	-	-	1	3
Total	65	100	35	100	30	100

As each respondent described a problem in his daily life associated with his visual loss, members of the field interviewing staff probed for the respondent's attitude toward receiving services in that particular area. In many instances, the respondent's answer was "No, not interested" for as many as four or five problem areas.

* 1 respondent in previous service
2 respondents, not interested in continuation of current services

Table of these listed companies at the following companies:

(List of companies in brackets that have been listed in the following table)

(In response to your request for information on the following companies, I have provided the following information)

(I have provided the following information on the following companies, as requested)

(I have provided the following information on the following companies, as requested)

I have provided the following information on the following companies, as requested. I have provided the following information on the following companies, as requested. I have provided the following information on the following companies, as requested.

Table of companies in brackets

The table of companies in brackets is provided for your information. It is not intended to be a list of companies, but a list of companies that are listed in the following table.

Table of companies

Table of companies provided by the following companies in brackets:

Company Name	2000		2001		2002	
	Revenue	Profit	Revenue	Profit	Revenue	Profit
Company A	100	20	110	25	120	30
Company B	200	40	220	50	240	60
Company C	300	60	330	80	360	100
Company D	400	80	440	110	480	140
Company E	500	100	550	140	600	180
Total	1500	300	1600	390	1680	490

The following table provides a summary of the financial performance of the companies listed in the table above. The table shows the revenue and profit for each company from 2000 to 2002. The total revenue and profit for all companies combined is also shown.

The following table provides a summary of the financial performance of the companies listed in the table above. The table shows the revenue and profit for each company from 2000 to 2002. The total revenue and profit for all companies combined is also shown.

The reasons for lack of interest given by respondents tend to cluster around three main factors already discussed: 1) their belief that specialized agencies are for the totally blind, a category into which this sample does not fit; 2) the presence of family members to assist them in daily living; and 3) a satisfactory accommodation to their visual loss. While on the surface it might appear that a dependency relationship had developed which is difficult for either the respondent or the family member to forego, it was not possible to determine within the framework of one interview the extent to which this is true. In many cases, there were implications of the intense desire to be independent, to retain a position in the sighted world which association with an agency for the blind appeared to threaten.

In the following respondent's remarks, we note the reliance on family members as the basis for rejection of service:

He doesn't think he needs to be trained to travel now, because he doesn't go that many places. Where he goes, relatives go with him. Respondent misses being able to read to himself very much, and gets mad when he cannot read. He never heard of talking books, and is not interested in them because his wife can read to him.

"The special agency is a place for people who have a special problem. -- I think agencies are OK for people to need them but I have a family; I don't particularly need them."

The presence of residual vision is given as the basis for the lack of interest in each of the following respondent's observations (coupled, in the second comment, with a hope that the respondent's eyes will improve):

"No, I haven't had the desire to contact any organization. So far, outside of reading and traveling, everything else I have been able to do. I'm not particularly interested and I feel right now I can manage. -- Maybe my eyes will become worse, -- but I'm able to get out, talk to people and associate with people. -- My home is all right. I've got a lot to be thankful for."

"The only place I heard from was the Y agency. (Wife: "We're hoping when he gets the other glasses he won't need no help.") I don't know how they got my name. They called and my wife told them I'm not totally blind. I don't know why they get in touch all the time. I think it was nice of them to call to ask if I needed glasses or help. I never knew of such places at all."

An emotional inability to cope with this loss of sight, combined with compulsive need for independence is indicated in this respondent's comments:

"He said I got this trouble because I'm a diabetic and have hardening of the arteries. If I had known what it was going to be like I would have allowed the operation back in '59. I tell you, Miss Smith, I am very very bitter. If I had known that life would be this miserable, I would have wanted them to operate, but my doctor was against it and said it would kill me. Even that would be better than not being able to see..."

"I'm not interested in any of these agencies that pity you and that's all those people who do that work in any of those agencies for the blind. Well, I don't want their pity - I don't want them to feel sorry for me. Miss Smith, I'm an independent man, I work hard, I pay my own way, I'm not dependent on anyone, never have been and never will be! I'm not totally blind -- I'll

never be a burden to my wife - it's not worth it, and I don't want her pity. If she wants to know anything about my eyesight I tell her to ask my doctors, not to talk to me about it. She knows not to say anything to me now because she knows how angry I get. I'm the man in this house and she does what I tell her. I don't want her doing things for me."

This woman gives her distaste of being with other blind persons as a reason for not accepting agency services:

"Long time ago, another lady from 23rd Street came. She say I come see her twice a week. Join groups. Don't want to see other people who can't see. I told her I can see very little."

These two respondents give peculiarities of their own personalities as the basis for rejecting services:

In response to the questions about services from a specialized agency, Mr. G. replied that he is "not sociable and is not interested in anyone else." He thinks of himself as "selfish" and feels that "most people are selfish". He feels that he knows all about specialized agencies or knows as much as he wants about them. He said that he doesn't want to "plan more than an hour ahead of time."

"I had a letter sent by the Y agency for the Blind. I wouldn't be adaptable for any rehabilitation mainly because of my temperament. I've always run things myself, and I don't feel it would be worth the effort to make a change. I don't think I want it, (a talking book machine) that's something I couldn't tolerate at all! I know a little about it and know how it is used, but I don't think I would want to be bothered. Some of these things I don't want because of my own personality."

An immobilizing depression is revealed in the comments of this respondent who states that he is not interested in rehabilitation services:

"I haven't been in touch with anybody. I have no information. I became depressed and didn't want to bother. I don't even like to think about it, I'll tell you the truth."

In spite of the long list of factors that contribute to the time-gap between the onset of blindness and offers of services to these respondents, it is clear from the depth interviews that there are many potential service cases with whom adequate communication has not been established.

35% of this Not In Service segment indicate either considerable or some interest in services. Internal evidence reveals that for many, the interviewer's probes regarding agencies and services were the first occasion on which the respondent had an opportunity to hear or think about such possibilities for himself. Thus, some of the negativism expressed can be attributed to the total newness of the subject matter, and to the understandable inability of the respondent either to identify adequately with these possibilities or to make decisions regarding his readiness to take advantage of them.

The need for more adequate information and a more effective means of communication with those not receiving services is indicated in the following comments. This respondent would accept services if transportation were provided:

Mr. P. thinks the agencies are good for people with poor vision, that are in different circumstances than he is. He feels that he does not "need to be involved" because he has a family. -- The main thing that has kept him from being in touch with one of these agencies or organizations is the lack of transportation. He feels that he would be "interested in going if the agencies provided transportation."

Another shows a willingness to accept help with self-care and still another seeks possible help (low vision aids) with his eyes:

"I am willing to go to one of these agencies for any kind of help they are willing to give me, whether there is a charge or not. I think most sightless people need help with keeping their clothes.

"I don't know anything about social agencies. What can they do for my eyes? Yes, I'm willing to try. I'll do it right away. Give me the address. Will they tell me about my eyes?"

Others reveal an interest in services, if they knew where to seek them:

"I don't know any organizations or people connected with braille. I would be interested to learn, but I don't know where to get in touch with an organization."

Other respondents treasure their independence and take pride in providing for themselves:

"I only had one visit by the investigator. Sometimes I call the office but they always change investigators. I think they do all right. I don't want to ask for anything and try to manage as best I can. I have always been independent and don't like to ask for things. After I get to be 62 years old I'll get my husband's social security benefits."

The significance of adequate communication with a person who has rejected services is perhaps nowhere in our study more dramatically illustrated than in the case of a woman with a profound fear of blindness who rejected the offer of services from a specialized agency because she felt it implied she would be totally blind. She is dependent upon her family, who were present during the interview. They expressed a desire to see her accept rehabilitation services and overcome some of her immobilizing fears. In the course of the interview, the respondent, for the first time since the onset of her serious visual difficulties, finds that she can communicate with someone from an outside organization:

Mrs. B. did not think she would like any training to travel outside her home by herself. She said that she does not know why but she is afraid of such training. She also does not see what they can do for her since she is not "blind" and does not use a cane or a dog or "anything like that" and "I don't have to". She says that they cannot do anything to make her get over this fear of traveling outside by herself and they cannot improve her vision so that they cannot help her. Here, it came out that she was contacted by the X agency but told them that she did not want their services. She did not know what services they were trying to offer her. She had never thought of being able to talk to a social worker but finds herself talking to me very easily, and since I am a social worker (she asked me what kind of training I had), she feels that she might be able to. She feels that the worker would have to come to her home -- the way that I did -- for her to feel comfortable in the situation.

IV. Concepts of Rehabilitation and Level of Information of Family Members of Blind Respondents

Within the time limitations imposed by the Pilot Study, one relative or friend of each of six blind respondents could be interviewed. Of these six blind persons, three are service cases, one is pending, and two rejected service. No definitive findings among their relatives or friends can be stated, but the interviews provided insights that could be useful in developing hypotheses for future research.

Of the four collaterals of Service Cases interviewed, (three family members and one close friend) three are well informed about the agencies and services. They encouraged the blind respondents to participate fully in the agencies' rehabilitation programs. Perhaps the most interesting of the observations about rehabilitation services made by non-medical collaterals comes from a young person, a friend of a young blind woman, who notes:

"Things shouldn't be done for blind people, if they can do them themselves. They should be taught to sustain themselves. Most blind people can do something and they should get away from the idea of weaving baskets. The first tendency of families is probably to do everything. The families need to be encouraged to help blind persons become more than a vegetable. They need to take pride in what he can do and expect him to do something.

"The family members can only teach personal skills such as dressing and caring for oneself. But their attitude should be, 'We're not going to be here forever so you'll have to learn to be independent.' Family can't teach braille, travel, job skills, etc. These things should be taught in a training center -- for several reasons, the person should be encouraged to get out of the house. It gives more of a feeling of self-reliance to have a place to go. They must learn to travel to get there and this is good. The feeling of 'I'm going somewhere' is important and it doesn't restrict his world so much. An agency should give this training -- like the agency X at --. It should be done as soon as possible before the person gets the opportunity to sit around and feel hopeless ...

"I encouraged M. to use the agencies and went with her to all the places the VRS counselor suggested. It was strange going to these places at first. I liked X best. They had a (blind) saleswoman who seemed to be like any other and she knew every item and where it could be found. She seemed to be leading a normal life. It's important for people to be able to say 'I work'."

The fourth collateral, the wife of a blind respondent whose case is pending in a specialized agency, is less well informed. While she appears to have no objection to his participation in a rehabilitation program, feelings and attitudes are guided by her husband's strong desire to be independent and his rejection, at this point, of an association with other blind persons. The wife says:

"I have never heard about them (agencies) until I started getting pamphlets in the mail. The lady downstairs tried to get him to give his name to agency X. He has told me he doesn't want to be around people who are blind. He has one view about blindness and she has another. She likes it; he doesn't like it ... No, I only hear about agency X, no other agencies."

The remaining two family members of blind respondents who were interviewed are in a high socio-economic group, well educated, and very active in professional or philanthropic circles. In neither instance did the family member have any firm conception of rehabilitation services nor any depth of knowledge about agencies. One spouse is a member of a board of directors handling materials for the blind, but knew nothing of available agencies and services. The spouse of another blind respondent had many years ago been a professional worker in a welfare program; yet knowledge of rehabilitation services for the visually handicapped was vague and generalized.

In both of these instances it would appear that a form of psychological blocking, related to the stigma attached to blindness, occurs and results in an informational and awareness gap. If this hypothesis were validated, in a larger sample, it would have a number of implications for new methods of communication with blind respondents in upper income groups as well as new ways of offering services.

V. The Hospital Social Service Director's Informational Needs

The Directors of Social Service Departments of hospitals, in their conference with the Pilot Study staff, discussed their own need for more information about specialized agencies and services and also their experiences with ophthalmologists.

a. Problems and Needs in the Social Service Departments

The Social Service directors were almost unanimous in their conclusions regarding the problems that affect their own awareness of available services. They indicated that:

1. The medical social worker and the Social Service departments must have more information of all resources available. In relation to this need, it was felt that the present workload of social service staffs creates a twofold problem:
 - a) that of absorbing the amounts of material which have to be passed on to staff members (on all kinds of questions, including rehabilitation services for a wide variety of handicapped persons);
 - b) an inability to undertake enough visits with the handicapped persons to see them through to desired goals.
2. It is vital to establish closer rapport between the Social Service departments and the specialized agencies for the blind, in order to close the time-gap between the onset of blindness and the reception of rehabilitation services. The directors indicated a need to explore additional ways of inter-relating to achieve the desired rapport.
3. It is important for staff of Social Service departments to know all of the steps at the specialized agency with which the blind patient must cope in order to fit this aspect of their knowledge of the patient's life into his total setting (school, neighborhood, job, etc.)
4. More research is needed and available research materials should be better known to those requiring them. The Social Service directors expressed the special need for more information regarding the practices of the specialized agencies.

The findings of the study indicate that the majority of respondents are in a state of moderate to high concern regarding the health of the community. The study also found that the majority of respondents are in a state of moderate to high concern regarding the health of the community. The study also found that the majority of respondents are in a state of moderate to high concern regarding the health of the community.

In both of these instances it was found that a high percentage of respondents are in a state of moderate to high concern regarding the health of the community. The study also found that the majority of respondents are in a state of moderate to high concern regarding the health of the community.

7. The National Health Service (NHS) and the Department of Health

The Department of Health and the National Health Service (NHS) are the two main bodies responsible for the health of the community. The study found that the majority of respondents are in a state of moderate to high concern regarding the health of the community.

8. The Role of the NHS and the Department of Health

The NHS and the Department of Health are the two main bodies responsible for the health of the community. The study found that the majority of respondents are in a state of moderate to high concern regarding the health of the community.

The study found that the majority of respondents are in a state of moderate to high concern regarding the health of the community. The study also found that the majority of respondents are in a state of moderate to high concern regarding the health of the community.

The study found that the majority of respondents are in a state of moderate to high concern regarding the health of the community. The study also found that the majority of respondents are in a state of moderate to high concern regarding the health of the community.

The study found that the majority of respondents are in a state of moderate to high concern regarding the health of the community. The study also found that the majority of respondents are in a state of moderate to high concern regarding the health of the community.

The study found that the majority of respondents are in a state of moderate to high concern regarding the health of the community. The study also found that the majority of respondents are in a state of moderate to high concern regarding the health of the community.

The study found that the majority of respondents are in a state of moderate to high concern regarding the health of the community. The study also found that the majority of respondents are in a state of moderate to high concern regarding the health of the community.

The study found that the majority of respondents are in a state of moderate to high concern regarding the health of the community. The study also found that the majority of respondents are in a state of moderate to high concern regarding the health of the community.

b. Ophthalmologists' Attitudes as Experienced by the Social Service Directors

With regard to ophthalmologists' understanding of rehabilitation services, their awareness and information, the Social Service directors were, again, almost unanimous in their opinion that:

1. Ophthalmologists, as previously discussed in Section E on False Hope, tend to feel guilty over the patient's loss of sight. They feel that "they have let the patient down", and as a result are reluctant to think about the value of rehabilitation:
2. Physicians are unable to envision rehabilitation: they tend to equate poverty with the need for service; they tend to think only in terms of jobs or vocational training if they consider rehabilitation services at all. Their understanding does not encompass training for mobility, self-care, home care, recreational and social services etc. The Social Service Directors emphasized that doctors reveal no realistic concepts of what goes into daily living; the rehabilitation services affecting the housewife and child care get almost no attention from physicians, and they confirmed the finding of other research studies* that doctors feel that blind women who have or want children "are out of their minds". They emphasized that the doctors have no awareness of home care, of the electrical appliances and other aids available to the modern housewife, or for that matter of the various appliances available to others in the household.

The Social Service directors feel that ophthalmologists are more limited in their concepts of rehabilitation services than other physicians.

VI. Ophthalmologists' Awareness of Agencies and Services

As has already been indicated, a fertile moment for developing awareness of rehabilitation possibilities in the visually handicapped occurs when the physician first determines that serious visual impairment has taken place. This is the opinion of many blind respondents, of professional workers with the blind, of medical social service workers and of some ophthalmologists in the sample. This opportune moment can be utilized only if the physicians themselves are convinced of the propriety and value of describing and suggesting rehabilitation procedures, and only if the physicians are themselves sufficiently informed to do so.

Ophthalmologists' perception of their own role in rehabilitation and their referral practices are discussed in detail in this chapter, Section I. This section will concern itself only with the conceptions of rehabilitation held by the blind respondents' ophthalmologists and private physicians and with the extent of their awareness of specialized agencies in the community best able to handle rehabilitation problems of the blind.

* Massachusetts Association for the Adult Blind, Research Proposal, "Providing Generalized Services to the Adult Blind" p. 6: "The private physician appears to be as subject to these barriers as any other professional person in the community. We have found this to be true both in the pilot program and in other programs of this agency. In the pilot program, a social caseworker talked with 16 gynecologists before finding one who felt that a blind woman had a right to have a child."

1. The following is a list of the names of the persons who have been appointed to the various committees of the Board of Directors, and the names of the persons who have been appointed to the various committees of the Board of Directors.

2. The following is a list of the names of the persons who have been appointed to the various committees of the Board of Directors, and the names of the persons who have been appointed to the various committees of the Board of Directors.

3. The following is a list of the names of the persons who have been appointed to the various committees of the Board of Directors, and the names of the persons who have been appointed to the various committees of the Board of Directors.

4. The following is a list of the names of the persons who have been appointed to the various committees of the Board of Directors, and the names of the persons who have been appointed to the various committees of the Board of Directors.

5. The following is a list of the names of the persons who have been appointed to the various committees of the Board of Directors, and the names of the persons who have been appointed to the various committees of the Board of Directors.

6. The following is a list of the names of the persons who have been appointed to the various committees of the Board of Directors, and the names of the persons who have been appointed to the various committees of the Board of Directors.

7. The following is a list of the names of the persons who have been appointed to the various committees of the Board of Directors, and the names of the persons who have been appointed to the various committees of the Board of Directors.

8. The following is a list of the names of the persons who have been appointed to the various committees of the Board of Directors, and the names of the persons who have been appointed to the various committees of the Board of Directors.

The Pilot Study sample of physicians (nine ophthalmologists and three general practitioners) is undoubtedly atypical of the profession with respect to their awareness of agencies and services. Out of 13 physicians interviewed, 11 are either attached to hospital clinics and/or are consultants to specialized agencies for the blind; two of the ophthalmologists are members of the Rehabilitation Committee of the Medical Advisory Committee of the New York State Commission for the Blind. However, even among some of these ophthalmologists, limited conceptions of rehabilitation were found. Examples revealed by the interviews follow: one ophthalmologist emphasized that his approach to offering rehabilitation services is based upon the patient's initiative rather than the physician's own conception of the patient's reality needs:

"Money and jobs, are the only things specialized needs include, nothing else. (Mobility training?) Do you mean learning how to walk? I think that's desirable. (Social and recreational needs?) Some want it, some do not want it. From a medical ophthalmological point of view, it is not a need. (Self-care?) I feel that it is up to them, whether they want it or not. (Reading skills?) I think they are desirable if they designate they have a need for it."

Some of the physicians interviewed understood the need for rehabilitation where it was associated with vocational training or job placement, but saw well-to-do patients as having no rehabilitation needs that could not be solved on an individual basis by "paying for them". It was not recognized that there are no profit organizations available to give such training:

"In regard to money, it would determine whether I would refer them to an individual or to an agency." (If a man has a half million dollars?) "Where would I send him? He could afford to pay someone to tutor him, to teach him to walk in his own home privately. This would depend on his economic status whether or not I would refer him to an agency."

Another physician saw rehabilitation needs in terms of young people exclusively:

"If a patient is very young, I do more to get him started on the right road. An old person, 80 to 85, you can't do much for them except to get them records to listen to. The younger the individual the more they need their minds occupied."

Almost all of the physicians in the interviewed sample stress the lack of information and awareness of services within the profession. These ophthalmologists report:

"It is my impression that few ophthalmologists know of the available services. They just don't have the information. They may receive it, but they don't seem to know about it. One of the problems is that we don't have time to read the material we get. For me to see the stuff that is mailed to me, someone has to convince my secretary that it is important for me to see it."

"Ophthalmologists are not aware at all of these agencies. None of the fellows (ophthalmologists) know how extensive the services are or are very much aware of these agencies."

The first thing I noticed when I stepped out of the car was the smell of the city. It was a mix of old and new, of history and progress. The air was thick with the scent of coffee from the nearby cafes and the faint, ever-present smell of exhaust from the cars. I took a deep breath, feeling the humidity of the city wrap around me. The sun was high in the sky, casting long shadows on the cobblestone streets. I looked up at the tall buildings, some with ornate facades and others that were more modern. The city was a blend of old and new, a place where the past and the future met. I felt a sense of excitement and anticipation as I walked down the street, taking in all the sights and sounds of the city.

As I walked, I noticed the people. They were a mix of ages and backgrounds, all going about their day. Some were in traditional dress, while others were in modern clothing. I saw a young girl in a school uniform, a man in a suit, and a woman in a colorful sari. The diversity of the city was evident in the people I met. I felt a sense of curiosity and a desire to learn more about the culture and the people. I saw a man in a white turban and a woman in a red sari walking together. They were talking and laughing, and I felt a sense of warmth and hospitality. I saw a young boy in a school uniform running towards me, and I felt a sense of joy and happiness. The city was a place of life and energy, a place where people were living and thriving. I felt a sense of awe and wonder as I walked through the streets, taking in all the sights and sounds of the city.

The architecture was a mix of old and new. I saw buildings with ornate facades and others that were more modern. The city was a blend of old and new, a place where the past and the future met. I felt a sense of excitement and anticipation as I walked through the streets, taking in all the sights and sounds of the city. I saw a man in a white turban and a woman in a red sari walking together. They were talking and laughing, and I felt a sense of warmth and hospitality. I saw a young boy in a school uniform running towards me, and I felt a sense of joy and happiness. The city was a place of life and energy, a place where people were living and thriving. I felt a sense of awe and wonder as I walked through the streets, taking in all the sights and sounds of the city.

As I walked, I noticed the people. They were a mix of ages and backgrounds, all going about their day. Some were in traditional dress, while others were in modern clothing. I saw a young girl in a school uniform, a man in a suit, and a woman in a colorful sari. The diversity of the city was evident in the people I met. I felt a sense of curiosity and a desire to learn more about the culture and the people. I saw a man in a white turban and a woman in a red sari walking together. They were talking and laughing, and I felt a sense of warmth and hospitality. I saw a young boy in a school uniform running towards me, and I felt a sense of joy and happiness. The city was a place of life and energy, a place where people were living and thriving. I felt a sense of awe and wonder as I walked through the streets, taking in all the sights and sounds of the city.

SECTION G

HOW ARE SPECIALIZED AGENCIES PERCEIVED -- THEIR IMAGE -- ATTITUDES
TOWARD -- EXPERIENCES WITH?

I. Image of the Agencies Among Those Not Receiving Service

The research findings indicate, as anticipated, considerable differences in their perceptions of specialized agencies between the Service Cases and those in the No Service Received segment.

The accompanying Table #16 shows:

Service Cases

- over half (60%) indicate clearly positive or accepting responses in their general attitudes toward experiences with the specialized agencies
- about one-third (33%) have some negative feelings or are non-committal ("Both", "Ambivalent" and "Non-committal" combined)

No Service Received

- less than one-third (28.5%) have clearly accepting or positive feelings about the agencies
- over one-third (34%) have some negative feelings ("Both" and "Negative" combined)
- another third (28.5%) are non-committal

Table #16

Attitudes of Blind Respondents Toward Specialized Agencies for the Blind

	TOTAL Sample (N-65)		No Service Received (N-35)		Service Cases (N-30)	
	N	%	N	%	N	%
Positive or Accepting	28	43	10	28.5	18	60
Negative	7	11	7	20	-	-
Both	8	12	5	14	3	10
Ambivalent	1	2	-	-	1	3
Non-committal	16	24	10	28.5	6	20
No information	5	8	3	9	2	7
Total	65	100	35	100	30	100

The interviews reveal that the "positive" attitudes among those receiving no services require careful definition and scrutiny because of their stereotyped quality. On the other hand, the negative feelings were expressed concretely and appear to stem from deeply felt -- if prejudiced -- anxieties and beliefs.

II. State of the Investment

The following table shows the investment in the various projects, as authorized, and the amount of the investment in the various projects as of the end of the fiscal year 1964.

The following table shows the investment in the various projects as of the end of the fiscal year 1964.

Investment

- The total investment in the various projects as of the end of the fiscal year 1964 is \$100,000,000.
- The total investment in the various projects as of the end of the fiscal year 1964 is \$100,000,000.
- The total investment in the various projects as of the end of the fiscal year 1964 is \$100,000,000.

Investment

- The total investment in the various projects as of the end of the fiscal year 1964 is \$100,000,000.
- The total investment in the various projects as of the end of the fiscal year 1964 is \$100,000,000.
- The total investment in the various projects as of the end of the fiscal year 1964 is \$100,000,000.

Table 1

Statement of Investment in the Various Projects as of the End of the Fiscal Year 1964

Project	1964		1963		Total
	Actual	Authorized	Actual	Authorized	
Project A	10	10	10	10	20
Project B	10	10	10	10	20
Project C	10	10	10	10	20
Project D	10	10	10	10	20
Project E	10	10	10	10	20
Project F	10	10	10	10	20
Project G	10	10	10	10	20
Project H	10	10	10	10	20
Project I	10	10	10	10	20
Project J	10	10	10	10	20
Total	100	100	100	100	200

The following table shows the investment in the various projects, as authorized, and the amount of the investment in the various projects as of the end of the fiscal year 1964.

a. The Image of the Agency Inhibits the Acceptance of Service

For the most part, among the respondents not receiving services, those who expressed positive attitudes and those who were non-committal (57%) shared one thing in common: lack of any clear information regarding the agencies or services with which they could identify.

The following positive comment incorporates the most detail of any of the favorable comments made by this segment:

"They pick up the people, give them lunch, sometimes they have to pay. I think they're good for people young enough to participate... No unfavorable impressions -- no agency that helps is unfavorable."

A 57 year old blind respondent who had telephone contact with a specialized agency reports:

"I think they're trying to help people. They were nice and friendly." He then says: "I feel that people at the agency are not like me. I get around pretty easily."

Thus it was found that although the visually handicapped person may have no negative impressions of the specialized agencies it does not necessarily follow that he is potentially interested in services. The analysis of the interviews indicates that much of the confusion over rehabilitation services and many of the prejudices associated with blindness are transferred to the specialized agency. This factor, combined with a low level of information about what the agency does and whom it serves (in terms of visual handicap) appear to create formidable barriers to an identification with the agency and consequently to an interest in its services. The most significant facets of this public image can be outlined as follows:

1. The specialized agency arouses anxiety regarding total blindness.

Over half of those not receiving services identify the specialized agency as a source of help to the totally blind. In a number of instances it was found that a communication from the agency -- meant to be informative and helpful -- was a source of anxiety since it was interpreted as a prognosis of future visual loss. Several persons in the No Service Received segment felt that a communication from, a referral by an ophthalmologist to, or any association with a specialized agency implied, medically, that total blindness is inevitable and imminent.

The following reactions to letters sent from specialized agencies were typical; one reported by a respondent and the other by an interviewer:

"I got hysterical when I got the letter from the New York State Commission for the Blind."

"She could not think of an unfavorable impression of this agency before she became aware of her own visual difficulties, but she was very much scared by the letter that she received from them. She feels they should have spoken to the doctor before they sent her a letter, which stated that they understand that she is "going blind". She feels that this gave her an unfavorable impression of the agency."

The first part of the report, which is the most important, describes the results of the study. It shows that the agency initiative has had a significant impact on the development of learning. This is particularly true for the group of students who were in the experimental group. The results are very encouraging and show that the agency initiative is a very effective way of promoting learning.

The following table shows the results of the study. It shows that the agency initiative has had a significant impact on the development of learning. This is particularly true for the group of students who were in the experimental group. The results are very encouraging and show that the agency initiative is a very effective way of promoting learning.

"The results of the study are very encouraging and show that the agency initiative is a very effective way of promoting learning. This is particularly true for the group of students who were in the experimental group. The results are very encouraging and show that the agency initiative is a very effective way of promoting learning."

A 27 year old child respondent who had been in the experimental group for a period of 12 months. The results are very encouraging and show that the agency initiative is a very effective way of promoting learning.

"I think that the results of the study are very encouraging and show that the agency initiative is a very effective way of promoting learning. This is particularly true for the group of students who were in the experimental group. The results are very encouraging and show that the agency initiative is a very effective way of promoting learning."

It is clear from the above that the agency initiative has had a significant impact on the development of learning. This is particularly true for the group of students who were in the experimental group. The results are very encouraging and show that the agency initiative is a very effective way of promoting learning. This is particularly true for the group of students who were in the experimental group. The results are very encouraging and show that the agency initiative is a very effective way of promoting learning.

The following table shows the results of the study. It shows that the agency initiative has had a significant impact on the development of learning. This is particularly true for the group of students who were in the experimental group. The results are very encouraging and show that the agency initiative is a very effective way of promoting learning.

One of the main reasons for the success of the agency initiative is the fact that it is a very effective way of promoting learning. This is particularly true for the group of students who were in the experimental group. The results are very encouraging and show that the agency initiative is a very effective way of promoting learning. This is particularly true for the group of students who were in the experimental group. The results are very encouraging and show that the agency initiative is a very effective way of promoting learning.

The following table shows the results of the study. It shows that the agency initiative has had a significant impact on the development of learning. This is particularly true for the group of students who were in the experimental group. The results are very encouraging and show that the agency initiative is a very effective way of promoting learning.

"I got interested when I got the letter from the New York State Office of Education for the State."

The results of the study are very encouraging and show that the agency initiative is a very effective way of promoting learning. This is particularly true for the group of students who were in the experimental group. The results are very encouraging and show that the agency initiative is a very effective way of promoting learning. This is particularly true for the group of students who were in the experimental group. The results are very encouraging and show that the agency initiative is a very effective way of promoting learning.

Her daughter thought it would have helped her mother if the doctor had discussed the services with her but felt that her mother probably would have been even more terrified in his office if he had mentioned that because her mother had always thought of the agency as a place for "blind people". Therefore, if the doctor thought that she ought to go there, then he must feel that she is going blind. The daughter said that she could not get her mother to understand what the agency could do for her and for other people who are not blind and were never going to be completely blind."

Another respondent, when asked by the interviewer whether she would be interested in participating in a program for rehabilitation services in an agency, replied: "No, no, just going there makes me feel more blind."

2. Transference of the stigma associated with blindness

Both the Service Cases and those receiving no services reveal a transference of the stigma previously discussed (this chapter, Section C) to the specialized agency.

The perception of the agency as a place for the "helpless", "dependent", "the poor" and "the lonely" is indicated by this respondent, not receiving services:

"I think agencies must be very cold so I prefer to stay at home. I have heard very little, (about agencies). I pass a home for the blind in the neighborhood. Poor creatures. Those people need help. They probably don't have families. They are just average people."

This Service case, conversely, states his insistence upon retaining his place and his identification with the sighted, indicating that the agency may be "necessary" for those "who have no friends":

"I always go with a group of people swimming and I still do. I do not believe in going to these service agencies to participate in these activities and associate myself with a new group when I can maintain contacts with my old sighted groups as before. I object to the idea of the principle of divorcing myself from my old friends. It may be necessary for those who have no friends - this may be indicated."

3. Negative clinic experience transferred to the agency

Several respondents reported negative experiences during the care and treatment of their eyes at clinics. The lack of personal interest on the part of clinic personnel, unwillingness of clinic doctors to provide adequate information, and the feeling by the respondents that they were part of an undifferentiated "mass" appears to have influenced a withdrawal from contact with other institutions where they might be treated likewise. A woman reports:

"They (clinic) said to come back again in a year. I could be blind now for all they care. -- They treat you just like cattle." When asked by an interviewer, what kinds of people did she imagine went to specialized agencies, she said: "Poor people, like myself -- not

rich people. Rich people with money go to good doctors and specialists -- places like that are nice -- they don't treat you like animals."

II. Attitudes of Service Cases Toward Experiences With the Agencies

As the previous table indicated (Table #16) three-fifths of the Service Cases indicated clearly positive or accepting general attitudes toward the agencies. Below is a typical respondent comment:

"When my real problems arose - I called the W agency and was put in touch with Mr. P. That opened a new world - he's a great counsellor - even when I hated him for some of the requirements I had to meet, he had my interests at heart. He said I could go to college. He put me in touch with the Y agency - I went for evaluation - the best thing I got from that was a boost in my self-confidence. They gave me faith in myself.

"I have no complaints about the agencies - they have been marvelous. My counsellor is tremendous. The social worker is great - he's blind - he sets an example of what one can do even though blind. I don't see him on a regular basis, but I know he's there if I need him. Some of the things the agencies ask you to do are annoying - application procedure - medicals, evaluation - but they are all helpful in the long run. The people I met were all understanding and concerned."

a. Problem Areas in Experiences With the Agencies

Table #17

Attitudes of Blind Respondents Toward Experiences With Specialized Agencies for the Blind

	<u>Service Cases</u>	
	<u>(N-30)</u>	
	N	%
Positive or Accepting	13	43
Negative	1	3
Both	8	27
Ambivalent	-	-
Non-committal	2	7
No information	6	20
<hr/>		
Total	30	100

The research findings also indicate that the clearly positive or accepting response of Service Cases to experiences with the agencies is less positive (43%) than are general attitudes toward these agencies (60%). (Table #17, above and Table #16, page 51) Moreover, about one-third (30%) of the Service Cases ("Both" and "Negative" combined) report some negative experience(s). The types of negative experience reported by the Service Cases can be outlined as follows:

1. Quality of initial contact is crucial

with people. This people are very good in their behavior and habits.
They are very kind and they are very good in their habits.

II. Attitudes of the people towards the government

In the present article, we have discussed the attitudes of the people towards the government. We have seen that the people are very good in their behavior and habits.

They are very kind and they are very good in their habits. They are very good in their behavior and habits. They are very good in their behavior and habits.

They are very good in their behavior and habits. They are very good in their behavior and habits. They are very good in their behavior and habits.

III. Attitudes of the people towards the government

Table III

Attitudes of the people towards the government

Attitudes	Percentage
Very good	15
Good	35
Fair	25
Poor	10
Very poor	15
Total	100

The present article, we have discussed the attitudes of the people towards the government. We have seen that the people are very good in their behavior and habits.

IV. Attitudes of the people towards the government

As discussed previously, the initial contact by the agency, whether through letter, telephone or personal visit, is crucial in the total process of convincing a legally blind person to consider his needs for rehabilitation services. The following respondent, a professional person, employed as a consultant, a person already quoted in the study as resisting the segregated aspect of the specialized agencies and as doubting that persons with interests compatible with his could be found in an agency setting, reports on the initial social work interview with him:

"I learned very little from the person who interviewed me. When she heard I was a doctor, she said that she did not think I needed any service and that I would not be interested in them. I felt that the social worker felt she just had to help me although it was obvious that I did not need any services. She mentioned a one-half bus fare but my wife drives me where I want to go. At the end of the interview I felt I had to take the one-half bus fare."

It appears that this respondent had limited concepts of rehabilitation services which were not broadened during his interview. It should be noted that this man had fallen down a flight of steps and sustained a skull fracture as a result of his mobility problems.

Another respondent who has had positive initial contact with an agency, feels that the agency is interested in him personally and in his specific needs:

"Prior to my eye trouble I used to donate to the Y agency for the Blind. I am not familiar with any other agencies. My only other contact has been with this agency and they got in touch with me. I do not know where they got my name, but after I applied for Social Security Disability benefits in June, 1965 I heard from the agency in July or August. I have had a few interviews and I was told that they would get in touch with me setting up the next appointment. They are to let me know about planning at a future time. I think they are doing all they can because they indicated they are also waiting to determine the best planning. I believe they may also be waiting the decision of the doctor about my condition.

"I have been real impressed with them because I believe they are out for my good. They want to help me train myself. Everyone has been simply nice."

2. Failure to follow through

There are a small number of Service Cases in the Pilot Study where there was a failure to follow through on offered services. Where this happens, the results are often tragic for the individual:

"I used to go to the Z agency. They would pick me up every Monday and I liked it. I looked forward to it every week. I don't go, they don't come to get me. I had a Spanish lady who was very nice. Spoke Spanish. She left. Told me to call when she left to go back to Spain. No, I didn't because they sent me American lady. Yes, I like it. Yes, I want to do it again. I only want someone to talk to. I do not care if they see or not. All people are the same in the eyes

of God. The Spanish lady told me about a watch I could tell by feeling it and a stick to help me walk. She left. I applied and it took two weeks for someone to come. They sent letters and took me to conferences, I liked it. -- I would like to go now but no one picks me up. I like to be with people."

3. Delay in agency services

Approximately one-fourth of the service cases report what appears to be an unnecessary delay in reception of agency services. An articulate and well-educated person who was able to follow through on a service he requested reports this delay:

"I had heard about it (talking book machine) on the radio or TV, I cannot remember which. A spot announcement was made. It was difficult to get a talking book. The kind of trouble you run into with private and government agencies. I called and was told to write. I did not hear and so I called again. I was told the mail had gotten lost. I called again and was told the person in-charge had lost a relative. What normally takes 4 to 6 weeks - this took 4 months before I got the talking book."

But a more passive person reports in December, 1965 of the social worker:

"She put my name on a list but I may have to wait till April. Lots of people are waiting ... Sometimes you got to wait and sometimes you are not getting anything."

Another aspect of the same problem is observed by this respondent to whom a rubber-tipped, especially measured cane was suggested two years ago by the specialized agency, but the social workers making the initial contact have not yet followed up:

"My opinion is not a good one. They all mean well-- send people to ask a lot of questions, but nothing ever really comes of it ... They all seem to work with volunteer workers. They have their own families to look after. They just don't have enough personnel."

4. Lack of individualized approach

The importance of this quality to respondents runs like a thread through many of the service case interviews. Another respondent makes this observation about the individuality of the visually handicapped:

"Sometimes I think the staff of the X agency feels we are senile. They sometimes seem this way when our ages are discussed as most of the people there are my age and older. I get the impression that they feel that we are really useless to society. I feel that they should treat people as individuals. --- I think that they ought to be aware that not all of us are the same and that there are some of us who are alert and know what's up. I think they all know and mean good."

5. Impact of the stigma within the agency

It will be recalled that a total of 57% of the Service Cases ("Negative" combined with "Both") have some negative attitudes toward segregated activities. (Table #7) In essence, the respondent just quoted in the previous section of the study, who feels that the agency regards blind people as "useless to society" is experiencing within that agency the impact of the stigma attached to blindness. Other respondents corroborate this experience.

This man feels the degradation of "handicapped" versus "real" wages:

"Also I think the W agency is a joke. A man gets paid for what he does. Either he should not get paid at all or he should be paid on a real wage basis. --- I think we should not be paid anything until we learn then we should get \$1.25 an hour and not this present 'coolie wage' setup. Hell, you can do better with a tin cup. All I do is voice my opinion. But you'd be surprised how afraid the men are to speak up."

This woman resists the isolation imposed by the stigma.

"I told them we shouldn't build fences around ourselves --- I'd rather talk about everything but my blindness, but no one seems to agree --- I don't want to live in a world all by myself, a world with just blind people. The agency meetings say that's the way it should be." She continues, "The agency seems to feel that they should stick together, but I don't, I differ from them - they should mingle and not have a club just for the blind. I don't know of any real answer as to why they stick together - if someone could get in and tell them differently. They feel - we're not wanted, we're in prison. It would make for a more normal existence if the two mingled."*

III. Suggestions for Improvements in Services

No significant frequency of suggestions for improvements occurred within the Service Cases. Rather, a wide variety of suggestions were made which appeared to grow out of the procedures of the individual agencies, and out of the visually handicapped person's subjective experience, which in itself reveals considerable variation. The suggestions made by clients for improvements in agency services are listed on the following page; the numbers in the parentheses signify the number of respondents making them:

* A proposal for a research project, "Providing Generalized Services to Handicapped People" developed by the Massachusetts Association for the Adult Blind, states: "In answer to the common statement 'that blind people like to be with their own', Father Carroll says: 'It is also true that there is strength to be derived from a group situation - when the group situation is controlled and is envisaged as temporary. The danger is that this strength will deteriorate into a 'misery loves company' situation, draining the strength of the individual and replacing it with dependence on the group. However, segregation has the terribly unfortunate result of building up minority feelings. It increases group hostilities rather than releasing them (as a group therapy situation might do), and in extreme instances, actually leads almost to a group paranoia.'" from Carroll, Thomas L., "Blindness, What It Is, What It Does and How to Live With It". Little, Brown & Co., Boston, Mass., 1961, Part IV, Chapter 25, page 330.

- Integrate: a) visually handicapped with sighted within the agency (3); (b) the sexes (1); c) visually handicapped and members of their families in agency activities (3);
- Conduct public education programs to break down the stigma attached to blindness (1);
- Assist visually handicapped client in establishing community organizational contacts and relationships (1);
- Help visually handicapped persons to improve their self-image and to upgrade their skills (1);
- Remove blind beggars from the streets and give them medical and rehabilitation services (1);
- Improve the vocational placement (job) service (2);
- Develop the vocational program within the agency as a regular job placement, at standard wages (1);
- Direct client away from excessive discussion of their personal problems and ailments to non-subjective topics (3);
- Develop better agency follow-up after initial client contact (4);
- Increase the number of days per week clients may participate in an agency program (2);
- Increase the number of braille teachers in the agencies and teach braille on an individual basis (1);
- Increase the number of activities during the client's days at agency, thus eliminating blocks of unutilized time (4);
- Provide more out-of-door, vacation activities (4);
- Provide swimming pool and water activities (3);
- Allow clients more initiative in suggesting trips outside established program (2);
- Develop activity programs for visually handicapped within the client's neighborhood (1).

Following are some of illustrative quotations from the respondents' interviews:

Better Follow-up

"My suggestions ---: less interviewing, more real help --- they should not just make promises, they should keep them too - It is no good, to make a promise and then you don't hear from them anymore --- Volunteer workers are fine people -- I really appreciate their coming over and help me to the clinic -- They should be picked from the neighborhood in which the blind person is living -- I guess, the people at the agency mean well, but they just don't seem to have the personnel ---."

Integrated Agency Activity:

"A place which caters to the multitude not just the visually handicapped, where I could bring my wife or daughter, even the physically handicapped could attend. If there is a swimming pool - anyone would be permitted to swim, thereby removing the stigma of segregation. Like a hiking group which should be mixed; so should social functions. You are labeled if you are segregated."

Rural Setting/Extensive Vocation Program

"My idea about an ideal organization for blind people would be that, if money is no problem, it should be a place outside of the city. It should be a school with large grounds that gives all types of training. It should provide all

kinds of activities and all types of training and skills according to the ability of the person. They would have swimming and games. Investigators in the field would go into industry to find placements and be sure that the blind person was treated like a person. I would expect to find very well trained qualified people there. The main thing is vocational training."

Improve the Self-image of the Visually Handicapped

"I think that blind people receiving training are not encouraged enough in elevating themselves. Only a few that I met were being helped to think in terms other than factory work. I think too many are told they are not capable of doing more. It seems that in order to get ahead (more than factory work) a blind person must have more than normal intelligence or he is not given the kind of encouragement I think he should get. If he's not capable he should be given even more help to become capable. He's not told what areas are open to him and he's not helped enough to move ahead. I saw prejudice in favor of the very bright college bound or the limited, but those in the middle seemed lost. I would expand the counselling service and social service to see if more couldn't be done with this."

Break Down the Stigma Attached to Blindness Through Public Education

"The most important things the agencies could do would be to educate the public - need a public relations job to take away the image of the blind as helpless and someone to fear. Blind speakers, professional people should go into the schools, churches etc. to break down stereotypes. Let people know what the blind can do. The blind also must help to build up their own image. I was upset by the exhibit of the blind at the Better Living Center at the World's Fair. Two people were behind a glass wall - like freaks or animals in a cage - one was doing Braille and one something else - people were looking at them."

IV. Use of the Word "Blind" in the Names of the Specialized Agencies

It has been hypothesized that the word "blind" in the names of specialized agencies may act as an inhibiting factor in the accepting or seeking of services. Consequently, members of the field staff probed for the attitudes of family members and physicians to this problem.

a. Family Members Reject the Word "Blind"

Four of the six family members commented on the use of the word "blind" in specialized agencies. Unanimously, they felt it an inhibiting factor in the seeking of services. Two wives of legally blind respondents state:

"The word "blind" is not the right word. A lot of people don't want to say 'blind'. It's the right idea but it would be better to say something like 'eyesight is limited'. Maybe the word 'blind' makes some people tremble because 'blind' more or less means such a permanent thing."

"The use of the word 'blind' - I never thought about it actively. Now that you ask, it gives me a creepy feeling - it goes to the pit of my stomach - I don't like to say my husband goes to the --- for the Blind. But how else can you identify the services of an agency, maybe by someone's name, but then the public wouldn't know what they do. We don't

want to call a spade a spade and I guess this is true about many things. I would much rather talk about my center as the Katherine Engels Center than the 'old people's club'. Yet, that is just what it is - 'senior citizen's center'. But it makes people feel badly and I think that 'blind' in the title might keep a lot of people away - especially those people with some sight."

The friend of a legally blind respondent comments on the need for some accurate names for organizations helping the visually handicapped:

"I like a symbolic name better, such as 'Lighthouse'. I think the word 'blind' does keep people away - especially those who have some vision. It is really harder in some ways for them because they don't really know where they belong."

b. Ophthalmologists' Attitudes Toward the Word "Blind"

Five of the physicians interviewed felt that the word "blind" would keep people away from the agencies, four indicated that it is not the name of the agency that inhibits service seeking, but the actual condition itself. The feeling of those finding the word "blind" objectionable in the agency name is typified by this comment:

"I feel that someone who is industrially blind or who has poor vision and is not actually blind (legally) will object to going to an agency that has the word 'blind' in the name. That's why I feel the term 'The Lighthouse' is good because it doesn't have the use of the word 'blind' in it. I don't think the New York Commission for the Blind is a good name. It would be better if the Commission was called the Commission for Visual Impairment. To be blind is a terrible stigma and a blind person doesn't want to admit his blindness."

The following comment is representative of those made by ophthalmologists feeling that the condition is the problem not the organization's name:

"It isn't the nomenclature, the patients reject, it's the condition. One of my children does not like eggplant; no matter how it's cooked she won't eat it. So it isn't the name of the place, it's the condition for which they must go there. Until they accept that, they just won't go."

On the basis of attitudes expressed by the visually handicapped toward the use of the word "blind" as an appropriate description of their visual loss; because of the severe anxiety which the word engenders among these respondents; because of the stigmata attached to the concept of the word "blind"; and because of the widespread belief that specialized agencies for the blind are for those with total loss of sight, it would appear desirable for agencies to weigh carefully the impact of the use of the word "blind" in the agency name.

... I think it is true about ...
... I would not have said ...
... I am ...
... especially ...

The ... of ...
... the ...

I like a ...
... I think ...
... it is ...

... the ...

... of the ...
... the ...
... the ...

... I think ...
... the ...
... the ...

The ... of ...
... the ...

... the ...
... the ...
... the ...

On the ... of ...
... the ...
... the ...
... the ...

SECTION H

FAILURE TO COMMUNICATE -- WHY?

THE PROBLEM OF COMMUNICATION: AN OVERVIEW

While there are other important causes for the time-gap between the onset of blindness and the acceptance of rehabilitation services, perhaps the most significant single reason is basically a communication failure. Throughout the study we have seen communication failure occur at all levels of the visually handicapped person's experience:

- where the impact of the social stigma attached to blindness blocks out awareness and understanding of the essential meaning of rehabilitation
- where the information is inadequate and "false hope" is given by the physician
- where the physician fails to inform of available rehabilitation services, or when there is failure to comprehend or perceive the information given
- where the messages of the specialized agencies fail to reach the visually impaired person, or if they do, they may be inappropriately conceived, not comprehended, or accepted
- where the visually handicapped person's conception of the specialized agency as a source of service is unacceptable and therefore the information received is ignored

Evidence of these communication difficulties have been drawn from the interviews with legally blind individuals, their family members and friends, their physicians and ophthalmologists. There are, however, a number of additional factors which derive, not from the subjective experiences and attitudes as expressed by the respondents, but rather from the social and psychological circumstances surrounding the individual.

In addition to the above factors there is evidence that each of the following had some influence on the communication between the visually impaired person in the sample and the person offering service.

a. Language Barrier

There were a few legally blind persons who did not understand English well enough to participate fully in the interview. It appeared that communication with these persons regarding rehabilitation services had been inadequate. It can be hypothesized, that any handicap which affects mainly older people in a multi-ethnic urban center such as New York City, will result in a disproportionate number of persons who have not learned to speak or understand English fluently. This suggests special programming by agencies for the blind.

b. Ethnic or Cultural Barriers

Within the Pilot Study there appeared to be at least six respondents, not receiving services, for whom going outside the family and outside

THE NATURE OF COMMUNICATION AS A PROCESS

While there are other important factors in the communication process, the most significant are the sender and the receiver. The sender is the person who initiates the communication, and the receiver is the person who receives the message. The message is the information that is being communicated. The channel is the medium through which the message is transmitted. The context is the situation in which the communication takes place. The feedback is the response that the receiver gives to the sender.

— show the impact of the social system on the communication process and the relationship between the sender and the receiver.

— show the relationship between the sender and the receiver and the impact of the social system on the communication process.

— show the relationship between the sender and the receiver and the impact of the social system on the communication process.

— show the relationship between the sender and the receiver and the impact of the social system on the communication process.

— show the relationship between the sender and the receiver and the impact of the social system on the communication process.

When we consider the communication process, we must take into account the social system in which it takes place. The social system is the set of relationships and norms that govern the behavior of individuals in a particular society. The communication process is a social activity, and it is influenced by the social system in which it takes place. The social system can facilitate or hinder communication, and it can shape the content of the message. The communication process is a complex and dynamic process, and it is influenced by many factors, including the social system.

In addition to the social system, there are other factors that influence the communication process. These include the sender and the receiver, the message, the channel, and the context. The sender is the person who initiates the communication, and the receiver is the person who receives the message. The message is the information that is being communicated. The channel is the medium through which the message is transmitted. The context is the situation in which the communication takes place.

1. Sender's Role

They are the individuals who initiate the communication process. They are responsible for encoding the message and transmitting it through the channel. They must be aware of the social system in which they are operating and the needs of the receiver. They must also be able to adapt their communication style to the situation. The sender's role is crucial in the communication process, and it is influenced by many factors, including the social system.

2. Receiver's Role

While the sender's role is important, the receiver's role is equally important. The receiver is responsible for decoding the message and interpreting it. They must be able to understand the sender's message and respond appropriately. The receiver's role is also influenced by the social system and the context of the communication.

the community for rehabilitation services would contradict their basic cultural pattern. These cultural patterns appear, on the surface, to be "dependency relationships", but there are indications that they stem from accepted cultural techniques, among certain ethnic groups, for coping with a family problem.* Closely related to entrenched cultural patterns are the problems which arise when a person, strongly conscious of his own ethnic background and sharply aware of the differences in "others", is asked to participate in the multi-ethnic setting which characterizes the modern community agency.**

Two persons consciously articulated this factor as a barrier to accepting services, one comments:

"We don't mix with Italians -- we don't mix... I'm afraid of the 'Spics' and other wild people in this building."

c. Financial Barrier

Half of the sample of the Pilot Study report an income under \$3,000 -- that is, under the "poverty level". The handicap of visual loss and age compound the problems of inadequate income and there are allusions to lack of carfare, inadequate clothing, etc. which hampers the blind persons in maintaining contact with the agency. The financial roots of the communication failure with persons below the poverty level appear to the Pilot Study staff to need further research.

d. Intellectual Barrier

The major reason for the exclusion of 11 interviewed persons from the sample was the mental retardation or incapacitation of the respondents. Only two of these respondents appear to suffer from the senility of old age; the others, according to the interviewers, appear intellectually incapable of understanding the questions and of providing relevant responses. The extent to which legally blind mental retardates lack agency services because of inability to comprehend the meaning and the sources of the services are areas for future research. The acceptance of services in many of these instances would appear to depend upon the ability of the agency to work with others in the home or in the blind person's environment.

e. "Specialized Language" Barrier

A barrier which affects many respondents in the sample where there are no language, ethnic, financial, or intellectual barriers, is the use of unfamiliar terms to describe rehabilitation services.

* See Gans, Herbert J., The Urban Villagers, Chapter 6, "The Outside World: Work, Education, Medical Care", p. 120, Free Press of Glencoe, New York, N.Y. 1963; and Saunders, L., Cultural Differences and Medical Care, Russell Sage Foundation, New York, N.Y. 1954.

** See Glazer, N. and Moynihan, P., Beyond the Melting Pot, M.I.T. Press, Cambridge, Mass., 1963

The research reveals that the usage of specialized terminology takes place at several levels: in written and verbal communications, and in personal visits by agency workers. Some of the terms of which respondents lacked understanding were: "talking book machines"; "braille"; "orientation"; "optical aids"; "self-care"; etc. Where interviewers took the time to explain the meaning and usefulness of one or more of these services, an increased interest in the service was expressed by some of the respondents.

It should be noted that the lack of comprehension of special terms used to describe rehabilitation services is not limited to the visually handicapped. Some ophthalmologists and physicians, some hospital social service directors, and some family members in the sample revealed a similar failure to understand the specialized language of the rehabilitation field.

The Pilot Study reveals the need for a simple, clear and informative approach, whether verbal or written, in all instances where the visually handicapped, their family members, their physicians, or any other persons active in relation to their visual loss, are contacted.

f. Other Barriers

The barriers listed above are not meant to be a complete list of those communication barriers which operate to isolate the visually handicapped from the specialized agencies. Nor can research with the size sample employed in the Pilot Study uncover the relative importance of those barriers revealed. Research within a larger sample would undoubtedly add to this list of factors, as well as relate them to the others that have been discussed in previous portions of the study.

The following table lists the names of the various committees, sub-committees, and working groups, and the dates of their formation. It is hoped that this information will be of some assistance to those who are interested in the work of the Commission.

It should be noted that the date of appointment of special agents is given in the table. It is not intended to imply that the agents were appointed on that date, but rather that they were appointed on or about that date.

The first step in the investigation was to identify the individuals who were likely to be involved in the case. This was done by reviewing the records of the Commission and by consulting with the various agencies and organizations which were known to be active in the field.

The following table shows the names of the individuals who were identified as being likely to be involved in the case. It is hoped that this information will be of some assistance to those who are interested in the work of the Commission.

SECTION I

HOW ARE REHABILITATION GOALS INFLUENCED BY MEDICAL PRACTICES?

I. How the Blind Respondents Feel About Their Doctors and the Adequacy of Their Medical Care?

Half of the blind respondents have accepting or have positive feelings about both their ophthalmologists and the adequacy of the eye medical care they have received. Approximately 30% more have some positive as well as some negative attitudes, and only 11% express definitely negative feelings. (see Tables #18, General Feelings Expressed by Blind Respondents Toward the Doctor(s) Who Have Examined Their Eyes, and #19, General Attitudes of Blind Respondents Toward Adequacy of Eye Medical Care, below) These findings reinforce the belief that the ophthalmologist is in a strategic position to influence his patient toward rehabilitation services. These services would be focused on the maximum use of residual vision and the learning of new skills which may substitute in part for those which he may be in process of losing. This is further reinforced by the report of the majority of the blind respondents that the time gap between onset of serious eye difficulty and the seeking of medical care was negligible. (87% of the respondents reported "none".) See Tables #20, Time Gap Between Onset of Blindness and Seeking of Medical Care, as Reported by Blind Respondents and #21, Time Gap Between Development of Serious Eye Condition and the Seeking of Medical Care, as Reported by Blind Respondents.

Table #18

General Feelings Expressed by Blind Respondents
Toward the Doctor(s) Who Have Examined Their Eyes

	TOTAL Sample (N-65)		No Service Received (N-35)		Service Cases (N-30)	
	N	%	N	%	N	%
Positive or Accepting	33	50	16	46	17	57
Negative	7	11	4	11	3	10
Both*	22	34	12	34	10	33
Ambivalent	2	3	2	6	-	-
Non-committal	1	2	1	3	-	-
Total	65	100	35	100	30	100

Table #19

General Attitudes of Blind Respondents Toward Adequacy of Eye Medical Care

Positive or Accepting	34	52	17	49	17	57
Negative	7	11	4	11	3	10
Both*	19	29	11	31	8	27
Ambivalent	3	5	2	6	1	3
Non-committal	2	3	1	3	1	3
Total	65	100	35	100	30	100

* "Both" indicates that respondent has had two or more experiences in which one or more was positive and one or more was negative.

Table #20

Time Gap Between Onset of Blindness and Seeking of Medical Care,
as Reported by Blind Respondents

	TOTAL Sample (N-65)		No Service Received (N-35)		Service Cases (N-30)	
	N	%	N	%	N	%
None	47	71	23	65	24	80
Less than 6 months	1	2	-	-	1	3
More than 6 months	9	15	7	21	2	6
Information not obtained	8	12	5	14	3	11
Total	65	100	35	100	30	100

Table #21

Time Gap Between Development of Serious Eye Condition and the Seeking of Medical Care,
as Reported by Blind Respondents

None	57	87	27	77	30	100
Less than 6 months	-	-	-	-	-	-
More than 6 months	5	8	5	15	-	-
Information not obtained	3	5	3	8	-	-
Total	65	100	35	100	30	100

Favorable attitudes toward medical personnel and the adequacy of eye care were based on the doctor's skill, gentleness, patience, honest explanation, individualization and understanding. The following quotation is illustrative: -

"If she could go to any eye doctor in the world, she would go to the same one that she went to. She said that she is still convinced that he is the best, that she would not completely believe anyone who told her that she would never go completely blind. She said that he is ideal -- he was kind and good and patient and let her cry and was sympathetic and took plenty of time with her and never minds her calling. She likes someone who handles her gently and does not rush her and explains things down to the last detail and will explain things over and over again if she says that she does not understand. She felt that he moved slowly and at her pace in the examination and the ensuing discussion. She thought that the examination was a thorough one and did not know anyone who could have done a better job."

Negative attitudes centered around incorrect diagnosis, lack of interest, lack of individualization, long period of waiting to be seen, doctor's unwillingness to give full explanation of eye condition. Illustrative quotations were, "I was in the clinic from 7:A.M. to 4:00P.M. - treat you terrible"; "He (the doctor) told me I had a cold instead of glaucma"; "They don't say anything unless you ask. They don't answer"; "They just use you for a guinea pig." In two instances blind

respondents felt that if there had been adequate diagnosis and treatment when they were children their sight would have been saved. Only in a very few instances did respondents indicate that they blamed themselves for their eye condition because they did not follow the doctor's advice.

The "wanting to know" runs like a refrain through the interviews and suggests that this expression of desire could be used constructively by medical personnel in opening the door to "next steps" in rehabilitation planning. The sensitivity of the doctor will always be needed in determining to what extent the desire to be informed is based on false hope and how much is really a desire for the full truth. As indicated in Section E on "False Hope", Table #13, page 38, it is significant that 40% of the blind respondents had some negative feelings about the adequacy of the medical information given to them by their doctors about their eye conditions. Why those in a service status are less satisfied than those who have received no service should be explored.

An attempt was made to determine whether there was a correlation between the doctor's expressed opinions about the value of informing his patients and the blind respondent's evaluation of the adequacy of the information he had been given. This was not possible, however, because the blind person's evaluation was usually related to contacts with several doctors, including the one interviewed in the sample.

A patient's interest in seeking his doctor's assistance in getting the skilled help he needs to meet the problems created by his eye condition would, it was hypothesized, influence the physician in his referral. Questions were therefore designed to elicit the opinion of blind respondents about the desirability of physicians giving rehabilitation suggestions. A surprising number in the total sample said they did not think it desirable - in fact over 50% of those from whom information was obtained. As indicated in Table #22, below, there was, however, a marked difference in the responses of those in the Service group and those in No Service Received. For those from whom information was obtained, in the No Service Received group only 33% felt it desirable for physicians to give suggestions, whereas 57% of those in the Service group who did consider it desirable.

Table #22

Opinion of Blind Respondents About the Desirability of Physicians Giving Rehabilitation Suggestions to the Visually Handicapped

	TOTAL Sample (N-65)		No Service Received (N-35)		Service Cases (N-30)	
	N	%	N	%	N	%
Positive	19	30	7	20	12	40
Negative	23	35	14	40	9	30
Information not obtained	23	35	14	40	9	30
Total	65	100	35	100	30	100

Major reason for not considering suggestions desirable, as expressed by several blind respondents, was in relation to seeing the doctor in a medical role only:-

respondents felt that it shows the doctor's diagnosis and treatment plan. They were often told that they would have been asked to do a very long questionnaire if they had not taken the doctor's advice.

The results of the study show that a certain number of respondents had a certain number of visits to the doctor. The results of the study show that a certain number of respondents had a certain number of visits to the doctor. The results of the study show that a certain number of respondents had a certain number of visits to the doctor.

An attempt was made to determine whether there was a correlation between the doctor's expressed opinion about the value of information his patients and the doctor's opinion of the value of the information he had been given. This was done by comparing the doctor's opinion of the value of the information he had been given with the doctor's opinion of the value of the information he had been given.

A patient's opinion in seeing his doctor's assistance in getting the doctor's help is not the only factor in the doctor's decision. The doctor's decision is based on many factors, including the patient's opinion, the doctor's own opinion, and the doctor's own opinion. The doctor's decision is based on many factors, including the patient's opinion, the doctor's own opinion, and the doctor's own opinion.

Table 1

Number of visits respondents took the responsibility of their own health care decisions according to the doctor's opinion

Doctor's opinion	No. of visits		Total
	Accepted	Not accepted	
Accepted	10	10	20
Not accepted	10	10	20
Total	20	20	40

Total number of visits: 40

These results show that the doctor's opinion of the value of the information he had been given is a significant factor in the doctor's decision to give his patients the responsibility of their own health care decisions.

"I really don't think doctors should take on this responsibility outside pure medical treatment unless they want to. They should tell you what is wrong with you and that's that."

"The doctor did not give me any information about places where I could go. I believe that it is the doctor's responsibility to give purely medical services."

"At the time I was only interested in what they could do medically. I wasn't interested in hearing about anything else."

"They, (the doctors) are so busy that they don't have time to do any suggesting like you are asking about. They always have a waiting room full of people."
(Not said in a hostile way.)

A perceptive observation relating to this preoccupation with medical concern was made by Professor Finestone after he had read the interviews of the Columbia University students whom he supervised. Underneath, he sensed a preconscious, somewhat irrational dissatisfaction with agencies because they will not cure blindness. If this is so, he asks, does this suggest something for casework - sensitivity to it, eliciting and dealing with these near-conscious negative feelings?

How the patient perceives the role of the doctor is important but how the doctor perceives his own role in the rehabilitation process is probably even more important.

II. The Doctor's Perception of His Own Role in Facilitating the Use of Community Resources

Responses of the 13 doctors interviewed to the question - "to what extent do you feel that ophthalmologists should be involved in helping blind persons meet their specialized needs (in relation to the eye handicap)?" - revealed considerable differences of opinion. Although the sample was too small for statistical analysis it would appear that the opinions followed the pattern found in the study* on the role of the ophthalmologist in the rehabilitation of blind patients, previously referred to on Page 36, which states:

"Of basic importance is the way the ophthalmologist defines his role in relation to the patient's social and emotional need. In the broadly representative sample, 10 per cent define their role as restricted to the medical aspects of eye pathology, 44 per cent extend this definition to include responsibility for referral of patients for rehabilitative services, and 46 per cent further extend the definition of role to include attention to the future social and emotional adjustment of blind patients. --

"In the small selected group of rehabilitation-oriented ophthalmologists none of the eighteen selected the narrowest definition of role as restricted to medical aspects of eye pathology."

* Finestone, Samuel and Dr. Sonia Gold, The Role of the Ophthalmologist in the Rehabilitation of Blind Patients, The American Foundation for the Blind, New York, N.Y., and The Seeing Eye, Morristown, N.J., 1959, Page 54.

The following quotations reveal the range of opinion among the doctors interviewed and also suggest a pressing need for the development of an agreed upon body of principles and practices to which both ophthalmologists and rehabilitation experts can subscribe. In connection with their role they say: -

"Informing, interpreting and supporting."

(underlining added)

"What I tell them depends upon the individual situation -- their age, health, their job needs, and so on -- I suggest specific steps."

"The physician should know the specific services and encourage the individual to utilize these services."

"Ophthalmologists can only recommend that the patient seek the proper agency. It is the job of the specialized agency to meet the patient's needs."

"I utilize the Social Service Department to carry through on any of these specialized needs. -- In the case of the legally blind client I expect the Commission for the Blind to carry through on the services but I leave it all up to the Social Service Department."

"This all varies with the individual. If he has friends or relatives to help him, I don't invade his privacy."

None of the doctors interviewed restricted his role exclusively to the medical aspects of eye pathology. Almost every doctor expressed a deep interest in assisting his patients and also a need to individualize them. However, unless he is fully aware of 1) the meaning of the various rehabilitation services and their use as they are tailored to the needs of different ages, different income brackets, different personality patterns, different health conditions, different educational levels, and 2) where the services are available, he will not be able to carry out the role he has defined for the ophthalmologist. As pointed out in sections F and G, which relate to specialized agencies and their services, there is a most serious lack of knowledge about both. This represents, as has been referred to previously, one of the most important areas of communication breakdown and suggests a pressing need for further study and planning.

III. Steps Which Might Be Taken to Change the Role of the Ophthalmologist

In a discussion about steps which might be taken to facilitate physicians playing a more active role in the rehabilitation of the blind patient, the members of the Physician Committee placed particular stress on the need to reach the ophthalmologist during his early medical training. Their suggestions embraced; training during the 2nd year residency with the inclusion of a six weeks indoctrination course (one afternoon per week) in a low vision clinic of a specialized agency; the involvement of County Medical Societies and the deans of medical schools in planning; training courses relating to rehabilitation under the auspices of the Public Health Service for doctors already in practice; individual appointments with practicing ophthalmologists by rehabilitation workers on a paid basis to interpret services.

Early training was also stressed as the most productive approach by the doctors included in the sample. Other suggestions included speakers at meetings of ophthalmologists; articles in medical journals; educational and interpretive literature, letters, pamphlets, mailed direct to the doctor's office; directory of all available services; a newsletter; material for the doctor to give to his patient and

his family. There was repeated reference to the problem of time pressure for the practicing ophthalmologist which results in his inability to read the literature he receives.

There was an indication that responsibility for assisting the ophthalmologist to play a more active role in rehabilitation planning was a shared one between the medical profession and the professional personnel in specialized agencies. The known need for such planning has been further documented by the findings of this Pilot Study and the timing would appear to be ripe. "How" the joint planning could best be done would require further exploration and study, but from the point of view of importance it is one of the most significant documentations of the Pilot Study period.

IV. Referral Practices of Ophthalmologists

Referral practices of the ophthalmologists interviewed were found to be a logical extension of their concept of their role. They ranged from active and continued involvement to a routinized reporting to the N.Y. State Commission for the Blind as required by law. More than half of those interviewed had some reservations about referral. In previous sections of this chapter the influence of the stigma attached to blindness, effect of gradual progression in the loss of sight, reluctance to admit blindness, false hope and perception of specialized services have already been discussed. There is also the clear indication that there is not wholehearted concurrence, among the physicians in the Pilot Study sample, with the belief held by experts in the field of services for the blind that "Any person who faces irreversible blindness, regardless of his financial and other resources, requires an "irreducible minimum of aid" in reorganizing his life ---."*

The report of blind respondents about their doctor's suggestions for specialized services corroborates the analysis of referral activity by doctors. Table #23, on the following page, indicates that more than fifty percent of the blind respondents claim no suggestions were made to them directly. Of those reporting that suggestions had been made, 65% were in the Service category. This suggests a favorable response and again supports the conclusion that the ophthalmologist has a crucial role, vis a vis rehabilitation.

The extent of variation in referral practices and attitudes is graphically illustrated in the following responses: -

"I do refer, in fact I'm practically a referral bureau." - versus - "I personally have never used a community service agency. I have never had call to do so."

"I tell the patient to go directly to the agency. In some cases, we will call from here." - versus - "I don't refer to the specific agencies. I let the N.Y. Commission for the Blind take care of that."

"The patient should be referred to the proper rehabilitative agencies immediately. Rehabilitative service starts at the bedside. Special organizations are

* "The Ophthalmologist in Rehabilitation", from The Role of the Ophthalmologist in the Rehabilitation of Blind Patients, American Foundation for the Blind, New York, N.Y. and the Seeing Eye, Morristown, N.J., 1959

There was an indication that respondents were more likely to report a positive attitude towards the health care system if they had a positive attitude towards the health care system in general. This finding is consistent with the findings of other studies which have shown that a positive attitude towards the health care system is associated with a positive attitude towards the health care system in general.

3.2. Cultural Perception of Health Care

The cultural perception of the health care system is an important factor in determining the health care system's effectiveness. The cultural perception of the health care system is defined as the beliefs, attitudes, and values that influence the health care system's effectiveness. The cultural perception of the health care system is influenced by a number of factors, including the health care system's history, the health care system's structure, and the health care system's culture.

The cultural perception of the health care system is also influenced by the health care system's communication. The health care system's communication is defined as the exchange of information between the health care system and its stakeholders. The health care system's communication is influenced by a number of factors, including the health care system's communication strategy, the health care system's communication channels, and the health care system's communication culture.

The cultural perception of the health care system is also influenced by the health care system's leadership. The health care system's leadership is defined as the individuals who are responsible for the health care system's direction and control. The health care system's leadership is influenced by a number of factors, including the health care system's leadership style, the health care system's leadership structure, and the health care system's leadership culture.

The cultural perception of the health care system is also influenced by the health care system's quality of care. The health care system's quality of care is defined as the extent to which the health care system provides care that is safe, effective, patient-centered, timely, and equitable. The health care system's quality of care is influenced by a number of factors, including the health care system's quality of care strategy, the health care system's quality of care standards, and the health care system's quality of care culture.

The cultural perception of the health care system is also influenced by the health care system's financial performance. The health care system's financial performance is defined as the health care system's ability to generate revenue and control costs. The health care system's financial performance is influenced by a number of factors, including the health care system's financial performance strategy, the health care system's financial performance standards, and the health care system's financial performance culture.

The cultural perception of the health care system is also influenced by the health care system's reputation. The health care system's reputation is defined as the health care system's standing in the eyes of its stakeholders. The health care system's reputation is influenced by a number of factors, including the health care system's reputation strategy, the health care system's reputation standards, and the health care system's reputation culture.

The cultural perception of the health care system is also influenced by the health care system's innovation. The health care system's innovation is defined as the health care system's ability to develop and implement new ideas and technologies. The health care system's innovation is influenced by a number of factors, including the health care system's innovation strategy, the health care system's innovation standards, and the health care system's innovation culture.

Table #23 (A) and (B)

A. Suggestions Made by Ophthalmologists or Other Physicians for Specialized Services in Relation to Blindness as Reported by Blind Respondents

	TOTAL Sample (N-65)		No Service Received (N-35)		Service Cases (N-30)	
	N	%	N	%	N	%
Rehabilitation suggestions made	20	31	7	20	13	43
Rehabilitation suggestions not made	37	57	21	60	16	54
Information not reported	8	12	7	20	1	3
Total	65	100	35	100	30	100

B .

Types of Suggestions Made

	(N-20)*	No. of Sug- gestions made (N-7)*	No. of Sug- gestions made (N-13)*
Specialized Agency Referral	13	2	11
Hospital Social Service Referral	4	1	3
New York State Commission for the Blind	2	1	1
General Service Agency (Non-blind)	2	1	1

qualified to handle specific and specialized needs." - versus - "The problem is that one is reluctant to suggest to anyone to go and consult so-and-so because 'You are going blind'."

"It (referral) requires a thorough knowledge of voluntary agencies and their functions as well as services offered." - versus - "A referral should be made to the New York State Commission for the Blind and they in turn contact places like the X. I feel that it's necessary to report to one only. I would prefer to handle it through the New York Commission for the Blind without contacting the agency that gives the services. If you don't there's too much duplication."

"I always give complete information to the rehabilitation people: the size of the visual field; the progression of the disease; anything that will be of help to them in servicing this person." - versus - "This all varies with the individual. If he has friends or relatives to help him, I don't invade his privacy."

* Multiple answers; will not add up to 100%

(3) (A) (1) (i)

The following table shows the distribution of the total number of cases by sex and age group for the period 1950-1954.

Age Group	Total		Male		Female	
	No.	%	No.	%	No.	%
0-4	10	10.0	5	50.0	5	50.0
5-9	15	15.0	8	53.3	7	46.7
10-14	20	20.0	12	60.0	8	40.0
15-19	25	25.0	15	60.0	10	40.0
20-24	30	30.0	18	60.0	12	40.0
25-29	35	35.0	21	60.0	14	40.0
30-34	40	40.0	24	60.0	16	40.0
35-39	45	45.0	27	60.0	18	40.0
40-44	50	50.0	30	60.0	20	40.0
45-49	55	55.0	33	60.0	22	40.0
50-54	60	60.0	36	60.0	24	40.0
55-59	65	65.0	39	60.0	26	40.0
60-64	70	70.0	42	60.0	28	40.0
65-69	75	75.0	45	60.0	30	40.0
70-74	80	80.0	48	60.0	32	40.0
75-79	85	85.0	51	60.0	34	40.0
80-84	90	90.0	54	60.0	36	40.0
85-89	95	95.0	57	60.0	38	40.0
90-94	100	100.0	60	60.0	40	40.0
Total	1000	100.0	600	60.0	400	40.0

Sex	Total		Male		Female	
	No.	%	No.	%	No.	%
Male	600	60.0	600	100.0	0	0.0
Female	400	40.0	0	0.0	400	100.0
Total	1000	100.0	600	60.0	400	40.0

The following table shows the distribution of the total number of cases by sex and age group for the period 1950-1954. The data is presented in a tabular format with columns for age groups, total cases, and the percentage of cases for males and females. The total number of cases is 1000, with 600 males and 400 females. The distribution is consistent across all age groups, with a 60% male and 40% female ratio.

* This number will not add up to 1000.

An ophthalmologist, deeply concerned about the non-use of specialized agencies by middle and upper income blind persons suggests these remedial steps: -

"I think (agencies for the blind) do a lot of good. But it does depend upon the class of person. I think we can't expect upper and middle class people to go to places like X.

"The abandoned and the destitute go anywhere as long as someone helps them, as long as anyone shows some interest in them."

(Probe: What would you suggest for upper and middle class people?) "I suggest the following: -

1. paid service
2. definite appointments
3. private interviews
4. private attention (i.e. training etc.)
5. a non-clinic approach
6. a setting in which people would not feel that they had been thrown and identified with a crowd of "blind" people - that is, a non-mass approach

"I believe there is a 'clinic type personality'. This person thrives on the social atmosphere of a clinic, they need the emotional support of a large group.

"And yet, the average middle class person, the white collar person is often the one who needs rehabilitation services the most. They have a good education, they have pride, they have the best chances for independence and they have almost no place to go."

Another ophthalmologist who is also deeply concerned about duplication of community efforts and quality of services suggests: -

"An investigation of the possibility of having one service for the blind in New York City with delegation of certain services to the present individual organizations. This would: -

1. aid in reducing confusion as to where patients should be sent
2. reduce duplication of effort and costs
3. make education of M.Ds. and the public infinitely easier
4. enable the development of a better total service for the blind."

He also feels that, "Initiating the rehabilitation program at the time the patient is still being treated - for example at the time low vision lens are indicated - will place less emphasis on 'blindness' and the definition of blindness (20/200) - will start rehabilitation earlier and at a time when the patient is still looking for better vision and the best use of his residual vision rather than 'rehabilitation' per se."

V. Mandatory Reporting as a Referral Device

The overwhelming majority of the doctors interviewed reported that they were in favor of N.Y. State's law which requires the reporting of legally blind persons to the N.Y. State Commission for the Blind. However, only one doctor felt there was complete compliance with the law. Since all except two of the doctors interviewed have hospital or clinic practices, or are consultants to rehabilitation agencies for the blind, they are undoubtedly more familiar with the reporting procedures than the majority of doctors who are only in private practice.

Their practice settings are as follows: (Table #24, following page)

an individual, usually, however, about the same as that of a group.

It is important to note that the individual is not a group, but a group is not an individual.

The individual is not a group, but a group is not an individual.

It is important to note that the individual is not a group, but a group is not an individual.

The individual is not a group, but a group is not an individual.

It is important to note that the individual is not a group, but a group is not an individual.

The individual is not a group, but a group is not an individual.

It is important to note that the individual is not a group, but a group is not an individual.

The individual is not a group, but a group is not an individual.

It is important to note that the individual is not a group, but a group is not an individual.

The individual is not a group, but a group is not an individual.

It is important to note that the individual is not a group, but a group is not an individual.

The individual is not a group, but a group is not an individual.

4. Individuality and Group Identity

The individual is not a group, but a group is not an individual.

It is important to note that the individual is not a group, but a group is not an individual.

The individual is not a group, but a group is not an individual.

Table #24

Practice Setting of Ophthalmologists and Physicians Interviewed

Private Practice Only	2
Private Practice Plus Other Setting	9
Information not obtained	2
	<u>13</u>
* Hospital or Clinic Practice	7
Chief or Asst. Chief of Hospital or Clinic Practice	3
Consultant to Specialized Agency for the Blind	4
Information not obtained	2

The doctors who are strongly in favor of reporting feel that "Statistics give one the necessary figures for meeting future needs of blind persons. Also such reporting is important to medical research. By not reporting, we deny future needs." Another comments, "It protects the blind person." Concern centers around: -

"The law is not strong enough. While the reporting is regarded as mandatory, there is no law that says you must. There is not nearly enough communication between the State and the ophthalmologist. The form definitely states that the reason is for statistical purposes. The forms should be meaningful. What I object to is the red tape. You have to make 12 copies of this and 12 copies of that. I feel they're (doctors) lax about it. -- I think it would help to have periodic reminders sent to them regarding the fact that they must report and send along some C.B.#104 forms to them. Physicians don't comply with the law because they forget. Ophthalmologists should be notified twice a year about reporting the blind to the State Commission. Nurses should get a separate letter reminding them to remind the doctors."

Lack of compliance with the law is confirmed when the time gap between the development of serious eye condition as reported by the blind respondents and receipt of an eye report by the Commission (Table #1) is examined. Many blind respondents indicated they had been examined in clinics and by private practitioners several years before an eye report was sent to the Commission. In some instances the persons may not at the earlier date, have fallen into the category of the "legally" blind but in many instances it seemed obvious that this was not the case. The non-referrals include persons in the middle and high income group. The extent that attitudes about referral of the middle and high income patients affects reporting has not been fully determined. In a study on resistance to cataract surgery, Irving Miller comments on the over-weighted representation of the lower socio-economic groups in the registration of the legally blind in New York State.**

* Multiple settings; will not add up to 13

** Miller, I., D.S.W., Resistance to Cataract Surgery, American Foundation for the Blind, 1964, p.27: "It also strengthened a widely shared presumption that coverage of the Registry tends to be selective and biased toward the lower socio-economic groups, i.e. those who use clinics, or those whose blindness is more routinely reported than otherwise, those who need the official designation of blindness afforded by the registration in order to become entitled to other rights and benefits (Aid the Blind, etc.)"

Partial Results of the Investigation of the ...

1950-1951

Partial Results of the Investigation of the ...

Partial Results of the Investigation of the ...

The data show a strong ...

The law is not ...

Lack of ...

Partial Results of the Investigation of the ...

The analysis of the ophthalmologist's perception of his role indicates that many regard a report to the Commission for the Blind as the limit of his responsibility. The major reasons for this limited concept appear to be: 1) lack of knowledge of agencies; 2) time limitations and; 3) a conviction there should be a central referral source. For example:

"The State Commission, not the doctor, should make the referral. I don't have too much information as to what the agencies do. -- I don't know what type of people the agencies take and therefore don't make referrals."

"The ophthalmologist can do more than just give his report to the State and give the patient the names of a couple of agencies to contact. Time and facilities are not available to the ophthalmologist to do anything else."

"I've seen a couple of patients shop around for agencies to go to. I don't think it's up to us to pressure them to go to any particular agency. -- The State agencies should take care of these people and help them to find the proper agency."

"A referral should be made to the New York State Commission for the Blind and they in turn contact places like the X. I feel that it's necessary to report to only one. I would prefer to handle it through the New York Commission for the Blind without contacting the agency that gives the services. If you don't there's too much duplication. I always refer my clients to N.Y. State. It's a law."

"I don't refer to the specific agencies. I let the N.Y. Commission for the Blind take care of that."

The above illustrations again support conclusions about the extent and complexity of the problem which is inherent in different perceptions of role among ophthalmologists. With respect to referrals the evidence indicates that "Mandatory Reporting" can be relied on only partially as a device for identifying blind persons in the population. Further research would undoubtedly uncover the extent of both late reporting and no reporting which delays rehabilitation efforts and creates a "hidden" or "lost" group of legally blind persons in the community.

CHAPTER V.

SUMMARY OF CONCLUSIONS AND RECOMMENDATIONS

In order to pinpoint the important findings and highlight the significant aspects of the Pilot Study, a Summary of Conclusions drawn from the research findings is presented in the following pages. These conclusions follow the structure of Chapter IV.

As previously suggested these findings and conclusions, which are based on relatively small samples, should be validated and developed through more intensive and extensive research studies.

A. HOW EXTENSIVE IS THE TIME-GAP BETWEEN ONSET OF SERIOUS EYE CONDITION AND THE OFFERING OF REHABILITATION SERVICES?

The Pilot Study has confirmed the hypothesis that an extensive and undesirable time-gap takes place between the onset of blindness and the offering of services:

-- for only 25% of the total sample was the time-gap less than one year

-- for 50% of the total sample it extended from three to over 20 years

The research indicates that no one factor appears to be the sole cause of the time-gap between onset of a serious handicap and the effective use of rehabilitation services. Rather, the gap appears to result from an inter-relating group of factors, many of which require further study. In addition to the social and psychological factors which have been uncovered (and which will be summarized in the following pages) there are a number of functional delays which appear to be part of the time-gap. Many of these delays are inherent in the problem itself and in the medical and legal processing which precedes an offer of services. Other delays appear to be avoidable.

Delays inherent in the problem include: the time required by the legally blind respondent to live with his handicap and become ready for services; the time taken by those appropriately involved in initial rehabilitation phases, such as hospital or clinic medical workers, family members, or general practitioners; the difficulty of diagnosis and prognosis of some eye diseases and unpredictability of treatment; the processing time involved in the ophthalmologist's report to the Commission or his referral directly to an agency, communications between the Commission and/or the specialized agencies and the legally blind person, the assignment of an agency worker, and the establishment of contact; the failure to locate the blind respondent because of the high level of mobility in large urban centers like New York City; the inaccessibility of persons because of incapacitating mental or physical illnesses in addition to blindness.

Avoidable delays include: failure or delay of some ophthalmologists to report as required by New York State law; delay in diagnosis of the eye disease due to the "shopping around" of the patient for additional medical opinions; insufficient or inconsistent follow-up for those not reached through usual channels of communication.

These delays which can add up to many months in the time lapse between onset of a serious eye condition and the offering of services has led to the conclusion that further study is needed to develop: 1) more efficient methods to reduce procedural blocks and 2) more skillful diagnostic tools to reduce the psychological barriers.

... to provide the program further and highlight the significant aspects of the plan, a summary of Connecticut cases and the various findings is presented in the following pages. These materials follow the structure of

... to provide the program further and highlight the significant aspects of the plan, a summary of Connecticut cases and the various findings is presented in the following pages. These materials follow the structure of

THE STATE OF CONNECTICUT
DEPARTMENT OF CONSUMER PROTECTION

... to provide the program further and highlight the significant aspects of the plan, a summary of Connecticut cases and the various findings is presented in the following pages. These materials follow the structure of

... to provide the program further and highlight the significant aspects of the plan, a summary of Connecticut cases and the various findings is presented in the following pages. These materials follow the structure of

... to provide the program further and highlight the significant aspects of the plan, a summary of Connecticut cases and the various findings is presented in the following pages. These materials follow the structure of

... to provide the program further and highlight the significant aspects of the plan, a summary of Connecticut cases and the various findings is presented in the following pages. These materials follow the structure of

... to provide the program further and highlight the significant aspects of the plan, a summary of Connecticut cases and the various findings is presented in the following pages. These materials follow the structure of

... to provide the program further and highlight the significant aspects of the plan, a summary of Connecticut cases and the various findings is presented in the following pages. These materials follow the structure of

... to provide the program further and highlight the significant aspects of the plan, a summary of Connecticut cases and the various findings is presented in the following pages. These materials follow the structure of

B. . WHAT ARE THE MAJOR REASONS WHY MANY VISUALLY HANDICAPPED PERSONS DO NOT SEEK REHABILITATION SERVICES PROMPTLY OR UTILIZE THEM WHEN THEY ARE OFFERED?

On the basis of the interviews with blind respondents, a list of 29 factors were identified which may cause or influence the seeking and utilization of rehabilitation services promptly.

The following factors were found to contribute most significantly to a time-gap between onset of blindness and seeking or accepting services. The findings also indicate that this lapse of time can seldom be attributed to a single factor, and that the inter-relationship of factors needs careful examination and study to determine which combination of causes contributes most importantly to the time-gap.

The social work and rehabilitation staff of The Jewish Guild for the Blind and the selected group of Hospital Social Service Department Directors were asked to select on the basis of their experience in working with legally blind persons, the six most inhibiting factors in seeking service. Their selection confirms the Pilot Study analysis of the responses of legally blind persons in the sample.

The factors selected fall into four major groupings:

Factors directly related to the person's own view of his situation and adjustment to visual loss:

- unwillingness and/or inability to accept visual handicap (legal blindness)
- false hope that eye condition will improve
- gradual progression in loss of sight (which allows for gradual accommodation)

Factors primarily related to attitudes, either of the blind person, his family or friends, medical personnel or the community at large toward :

- blindness (stigma, guilt, shame etc.)
- acceptance of services from a voluntary agency (charity concept, client role, ethnic groups served etc.)
- segregation of the blind.

Factors related to general personality patterns:

- Apathy
- Lack of motivation
- Resistance to change
- Need to retain a dependent role.

Factors related to agencies:

- Lack of knowledge about the nature of specialized services
- Failures in communication
- Failures in referral practices

C. SOCIAL STIGMA ATTACHED TO BLINDNESS -- THE MOST SERIOUS DETERRENT?

The social stigma attached to blindness appears to be a major factor in the seeking or acceptance of rehabilitation services. The stigma -- the negative qualities attributed to blindness by society -- appears to operate both subtly and overtly in relation to blind respondents in the sample.

2. THE FACTORS WHICH AFFECT THE DEVELOPMENT OF THE VISUAL PERCEPTION OF OBJECTS IN THE VISUAL FIELD

On the basis of the research with blind persons, a list of 25 factors was compiled which may have an influence on the development of visual perception.

The following factors were found to influence the development of visual perception: 1. The degree of blindness and the nature of the visual field. 2. The degree of development of the other senses. 3. The nature of the objects in the visual field. 4. The nature of the environment. 5. The nature of the social conditions. 6. The nature of the educational conditions. 7. The nature of the cultural conditions. 8. The nature of the economic conditions. 9. The nature of the political conditions. 10. The nature of the social conditions. 11. The nature of the cultural conditions. 12. The nature of the economic conditions. 13. The nature of the political conditions. 14. The nature of the social conditions. 15. The nature of the cultural conditions. 16. The nature of the economic conditions. 17. The nature of the political conditions. 18. The nature of the social conditions. 19. The nature of the cultural conditions. 20. The nature of the economic conditions. 21. The nature of the political conditions. 22. The nature of the social conditions. 23. The nature of the cultural conditions. 24. The nature of the economic conditions. 25. The nature of the political conditions.

The results of the research show that the development of visual perception is a complex process which is influenced by a number of factors. The most important factors are the degree of blindness and the nature of the visual field. The other senses also play an important role in the development of visual perception. The nature of the objects in the visual field and the nature of the environment also have an influence on the development of visual perception. The nature of the social conditions, the nature of the educational conditions, the nature of the cultural conditions, the nature of the economic conditions, and the nature of the political conditions also have an influence on the development of visual perception.

The factors which affect the development of visual perception

Factors which are related to the person: 1. The degree of blindness and the nature of the visual field. 2. The degree of development of the other senses.

- development of the other senses (hearing, touch, etc.)
- the nature of the objects in the visual field
- the nature of the environment

Factors which are related to the object: 1. The nature of the objects in the visual field. 2. The nature of the environment.

- blindness (total, partial, etc.)
- the nature of the objects in the visual field (size, shape, color, etc.)
- the nature of the environment (light, sound, etc.)

Factors which affect the development of visual perception

- the degree of blindness
- the nature of the visual field
- the degree of development of the other senses
- the nature of the objects in the visual field
- the nature of the environment

Factors which affect the development of visual perception

- lack of knowledge about the nature of the objects in the visual field
- the nature of the objects in the visual field
- the nature of the environment

3. THE FACTORS WHICH AFFECT THE DEVELOPMENT OF THE VISUAL PERCEPTION OF OBJECTS IN THE VISUAL FIELD

The results of the research show that the development of visual perception is a complex process which is influenced by a number of factors. The most important factors are the degree of blindness and the nature of the visual field. The other senses also play an important role in the development of visual perception. The nature of the objects in the visual field and the nature of the environment also have an influence on the development of visual perception. The nature of the social conditions, the nature of the educational conditions, the nature of the cultural conditions, the nature of the economic conditions, and the nature of the political conditions also have an influence on the development of visual perception.

Half of the respondents do not consider themselves "blind" nor do they regard the term "blind" as an appropriate description of their eye condition. To many, "blindness" means total loss of vision.

Ophthalmologists in the sample emphasize the problem of denying blindness is complicated by a wholesome desire to utilize partial vision fully. The failure to use functional definitions of blindness, leaves those with partial vision in a "No Man's Land" regarding services, particularly when they believe, that the specialized agencies are for the totally blind only. The findings corroborate the importance of the need, frequently expressed in the field of services for the blind, for more adequate and functional definitions of visual loss.

A major source of the respondent's negative feelings toward blindness, is derived from the prejudices of the society in which they live. These prejudices view blind people as inherently "helpless"; "dependent"; "pitiful"; "useless"; "unhappy"; etc. The desire to avoid being so labelled appears to lead many respondents to deny the extent of their visual handicap. They thus simultaneously deny themselves the training which would improve their functioning and increase their emotional and social satisfactions. While the inability to accept blindness is sometimes expressed in purely psychological terms related to the person's individual emotional capacity and willingness to cope with his handicap, the Pilot Study again confirms knowledge in the field that this inability is compounded to a major degree by the social factors described.

More negative than their attitudes toward blindness per se are many respondents' attitudes toward relationships with other blind persons and toward participation in activities in which the blind and sighted are separated. The findings indicate that:

- 87% of those not receiving services and 64% of the Service Cases have some negative attitudes toward relationships with other blind persons
- 71% of those not receiving services and 57% of the Service Cases have some negative attitudes toward activities in which the blind and sighted are separated

Relationships with other blind persons and segregated activities appear to have a three-fold effect upon many respondents: 1) they experience an intensification of their own visual handicap; 2) they anticipate loss and deprivation of both position and role in the sighted world; and finally, 3) they experience a sense of isolation, being "imprisoned" by the relationships with blind persons, derived in part from what is described as the pre-occupation of blind persons with their ailments and their handicap.

The resistance to accepting a marginal role in society appears very strong among many respondents, both those receiving and those not receiving services. The articulated desire to be or to remain independent, found among 74% of the sample, appears to be a statement of this resistance. The expressed desire of respondents to be independent may, on further investigation, be found to be more verbal than real. It is considered important that the conceptualization of an independent role by blind persons should be studied further in terms of its planned use in stimulating interest in rehabilitation services.

A major conclusion of the Pilot Study, based upon the extent of the rejection of blindness and the relationships associated with it, is the urgent need of programs

...of the respondents as well as the respondents' ...

...the respondents' ...

designed to educate public opinion and to eliminate, or at least modify and neutralize, the existing prejudices against blindness and blind people.

D. WHAT IS THE EFFECT OF GRADUAL PROGRESSION IN THE LOSS OF SIGHT?

The gradual progression of blindness, whether due to age or to disease, which characterized many instances of blindness appears to bring with it a passive acceptance of the handicap and a consequent accommodation at a lower level of functioning. This lower level of functioning seems especially characteristic of many respondents not receiving services.

It is apparent that gradual progression of the onset of blindness tends to encourage a denial of the severity of the handicap. This, in turn, appears to result in an unnecessary loss of skill which could have added immeasurably to the comfort, the enrichment and the sense of usefulness in the blind person's life.

It is concluded, therefore, that at all levels of contact special attention is needed to those suffering a gradual progression in the loss of sight. Ophthalmologists, medical social workers in hospitals and clinics, case workers in general and specialized agencies, families and friends need to be especially aware of the possibilities of improving the level of functioning of those persons who, over a long period of time, have gradually accommodated themselves to a degree of inactivity and immobilization which could be decreased if they were to receive rehabilitation services.

E. FALSE HOPE, A DETERRENT IN REHABILITATION?

The findings indicate that many legally blind persons resist rehabilitation services on the grounds that their eyes will "eventually get better".

False hope of visual improvement appears to have several sources. Among the most important are: 1) failure of the ophthalmologist to inform the patient when his visual loss is irreversible; 2) failure by the physician to give explanations (in lay terms); 3) the emotional need of the blind person to create false hope in order to cope with his anxiety and thus an inability to accept or "hear" the prognosis; 4) on-going clinic visits, encouraged by the clinic setting, which are interpreted by the patient as a possibility of visual improvement.

Those ophthalmologists in the sample who are aware of the potentialities of early rehabilitation services regard false hope as an impediment to rehabilitation. The majority of legally blind respondents indicate verbally that they wish to know the exact nature of their eye condition.

A substantial proportion of blind respondents claim that there was no gap in seeking medical care either after the onset of their eye condition (71%) or after the development of a serious eye condition (87%). These claims reinforce the conclusion that the ophthalmologist appears to be in a crucial position to influence the blind patient in recognizing the extent of his visual loss and in relation to early rehabilitation services.

The findings lead to the further conclusion that it is important through further research and study to develop criteria through professional medical discussions to guide ophthalmologists in informing the patient where severe irreversible visual loss occurs.

...to discuss further options and to discuss, in at least some cases, the relative importance of different and other factors.

D. WHAT IS THE EFFECT OF CHANGING PROGRAMS IN THE 1950s?

The gradual improvement of education, whether due to the fact that the educational system has improved or to the fact that the educational system has improved, is a result of the fact that the educational system has improved. This level of improvement is a result of the fact that the educational system has improved.

It is apparent that the educational system has improved, whether due to the fact that the educational system has improved or to the fact that the educational system has improved. This level of improvement is a result of the fact that the educational system has improved.

It is concluded, therefore, that at all levels of educational attainment, the educational system has improved, whether due to the fact that the educational system has improved or to the fact that the educational system has improved. This level of improvement is a result of the fact that the educational system has improved.

E. THE EFFECT OF CHANGING PROGRAMS IN RESEARCH

The findings indicate that the educational system has improved, whether due to the fact that the educational system has improved or to the fact that the educational system has improved. This level of improvement is a result of the fact that the educational system has improved.

The findings indicate that the educational system has improved, whether due to the fact that the educational system has improved or to the fact that the educational system has improved. This level of improvement is a result of the fact that the educational system has improved.

The findings indicate that the educational system has improved, whether due to the fact that the educational system has improved or to the fact that the educational system has improved. This level of improvement is a result of the fact that the educational system has improved.

The findings indicate that the educational system has improved, whether due to the fact that the educational system has improved or to the fact that the educational system has improved. This level of improvement is a result of the fact that the educational system has improved.

The findings indicate that the educational system has improved, whether due to the fact that the educational system has improved or to the fact that the educational system has improved. This level of improvement is a result of the fact that the educational system has improved.

F. HOW MUCH IS KNOWN ABOUT SPECIALIZED AGENCIES AND THEIR SERVICES?

A limited awareness of specialized agencies for the blind, and a corresponding lack of information about the kinds of rehabilitation services available is clearly apparent. This lack of awareness and information occurs among:

- the visually handicapped respondents who did not respond to an offer of services;
- among the ophthalmologists who seem, in point of timing and authority, to be in the best position to advise and inform the visually impaired;
- among medical social workers upon whom the physicians in hospitals and clinics frequently rely for rehabilitation information, and who are likewise in a good position to inform and suggest rehabilitation to the visually handicapped;
- among family and friends upon whom rests a great burden of physical assistance and moral support to the blind person.

Lack of information led to limited concepts of rehabilitation. Rehabilitation services were largely thought of in terms of jobs or braille. There was little understanding of other services including mobility training; self-care; home-care; group work activities; casework; psychological testing; vocational evaluation and training; optical aids and informational services. Because of lack of information, long term "accomodation" to their handicap and other reasons respondents not receiving services revealed only a slight interest in receiving them: 65% indicated that they were "not at all" interested, and only 26% indicated they were "somewhat" so.

The conclusion is that the problem is not one of quantity or volume of information. The most compelling need is for informational material, sufficiently diversified in content and in a form that can be used in reaching a wide variety of lay and professional persons in the community.

G. HOW ARE SPECIALIZED AGENCIES PERCEIVED -- THEIR IMAGE -- ATTITUDES TOWARD -- EXPERIENCES WITH?

A sharp difference in the feelings about specialized agencies is found between the attitudes of those not receiving service and the Service Cases. Twice as many Service Cases (60%) revealed positive attitudes toward the agencies as those not in service (28.5%).

Among those not receiving services the major negative attitudes cluster around these impressions:

- over half identify the specialized agency as a source of help to the totally blind. A communication from a specialized agency is found to arouse fears of becoming totally blind.
- many perceive the agency in terms of the stigma attributed to blindness: as a place for the "helpless"; the "dependent"; the "lonely" and as "isolating" from the normal and familiar world
- the use of the word "blind" in the names of specialized agencies has an inhibiting effect
- a transfer to the agency of negative experiences in clinics including a non-individualized approach

The positive attitudes of the Service Cases toward the agencies emphasized:

- very substantial assistance with specific problems such as counselling, vocational guidance and training in such skills as mobility, home care, self care, braille, etc.
- warm professional relationships with social workers and rehabilitation workers
- stimulation and enjoyment derived from recreational, craft, educational and other activities
- the function of the agency program in reducing isolation and inactivity

The negative feelings of the Service Cases toward experiences with specialized agencies center around:

- the quality of initial contact in instances where it was superficial and routine without an attempt to fit available services to the needs and interests of the individual.
- a failure to follow through after initial contact including keeping promises of assistance
- delays in reception of services including "red-tape"
- segregated activities in relation to isolation and stigma

The nature of the problem areas identified by blind respondents and others participating in the study, suggests that many could be resolved through administrative action, staff training and community action without further research. However, the low level of information referred to in the previous section (F) combined with the negative image of the agencies among those not receiving services suggests the need for a program of public education about the agencies: what they do; whom they serve; and the individualized evaluation and consideration given each potential client. How this can best be done is subject to further study and research.

H. FAILURE TO COMMUNICATE -- WHY?

The findings suggest that perhaps the most significant single reason for the time gap is a communication failure. The communication failure appears to occur at many levels of the visually impaired person's experience:

- where the stigma attached to blindness blocks out awareness and understanding of rehabilitation services which are related to visual loss
- where inadequate information is given by the physician and "false hope" develops
- where the physician fails to inform about rehabilitation services or if information is given it is not understood
- where the agency fails to communicate its offer of service in a way which is meaningful
- where the information received is ignored because of a negative conception of the specialized agency

In addition to the above communication failures, drawn largely from the interviews, are those which derive from the social and cultural environment surrounding the blind individual. The following environmental barriers appear significant:

1) language - with two major areas of difficulty, a) those unable to comprehend English and b) specialized and often cumbersome language used by rehabilitation agencies; 2) ethnic or cultural - where traditional cultural patterns bar the seeking of assistance outside the immediate family and/or community; 3) financial - half of the Pilot Study sample report an income of under \$3,000 which appears to effect the individual's ability to communicate with the agency; 4) intellectual - the exclusion from the sample of a number of persons who are mentally retarded or mentally incapacitated suggests a number of persons in the legally blind population who may lack the ability to comprehend the meaning and sources of services as they are presented to them.

Based on the extent and variety of communication failures which serve as barriers between the visually handicapped and services from specialized agencies, further study is needed for the development of improved communication methods.

I. HOW ARE REHABILITATION GOALS INFLUENCED BY MEDICAL PRACTICES?

The research findings indicate that ophthalmologists are in a particularly advantageous position to assist the visually handicapped in having the opportunity to utilize rehabilitation services. It has been noted previously that almost nine-tenths of the respondents reported seeking medical care soon after the development of a serious eye condition. In addition, over four-fifths of the sample expressed positive feeling both toward the doctors who examined their eyes and toward the adequacy of the eye medical care they received.

In the light of these responses, it is particularly important to note that only 31% of the respondents reported that ophthalmologists made rehabilitation suggestions to them. Twice as many Service Cases as those not receiving services reported such suggestions.

How do ophthalmologists view their rehabilitation role? The Pilot Study research reveals a wide diversity of opinion among ophthalmologists in the sample regarding their role and varying levels of comprehension of rehabilitation services. They express a deep interest in helping their patients and in having available to them the means to do so. A factor which may have affected the ophthalmologist's concept of his role is that over 50% of those blind persons responding, felt that it is "not desirable" for the physician to give rehabilitation information. They regard him as having a medical role only.

Many suggestions were made by members of the Physicians' Committee to assist ophthalmologists in playing a more active rehabilitation role. The most important of these include: early medical school training in rehabilitation services and sources; utilization of the Public Health Service for doctors already in practice; the development of a central referral bureau which would, it is felt, reduce duplication of cost and effort; facilitate medical and public education; and develop a better total service for the blind.

The findings indicate that the majority of ophthalmologists in the sample favor the New York State law making mandatory the reporting of legally blind persons to the New York State Commission for the Blind. At the same time, most ophthalmologists felt that there is a low level of compliance with the law. This is confirmed by the extent of the time-gap between onset of blindness and the offer of services. The Pilot Study and other research previously referred to reveal what

It is necessary to have a clear idea of the nature of the problem to be solved. The first step is to define the problem in terms of the objectives to be achieved. This involves a careful study of the requirements and the resources available. The next step is to develop a plan of action. This involves determining the steps to be taken and the order in which they should be taken. The final step is to execute the plan and to evaluate the results. This involves carrying out the steps of the plan and then comparing the actual results with the expected results. If there are any differences, it is necessary to identify the causes and to take corrective action.

Based on the extent and nature of the problem, it may be necessary to consult with other people. This is especially true if the problem is complex or if it involves a large amount of money or resources. Consulting with others can help to provide new ideas and perspectives, and it can also help to ensure that the plan is realistic and achievable.

1. HOW ARE PROBLEMS IDENTIFIED BY THE RESEARCHER?

The researcher identifies a problem when he or she becomes aware of a discrepancy between the current state of affairs and a desired state of affairs. This discrepancy may be caused by a change in the environment, by a change in the requirements, or by a change in the resources. The researcher then seeks to identify the causes of the discrepancy and to determine the steps that need to be taken to resolve it.

In the identification of a problem, the researcher must first determine whether or not there is a problem. This involves comparing the current state of affairs with the desired state of affairs. If there is a discrepancy, the researcher must then determine the causes of the discrepancy. This may involve a careful study of the requirements and the resources available.

Once the researcher has identified a problem, the next step is to develop a plan of action. This involves determining the steps to be taken and the order in which they should be taken. The researcher must also determine the resources that will be needed to execute the plan. The final step is to execute the plan and to evaluate the results. This involves carrying out the steps of the plan and then comparing the actual results with the expected results.

The researcher must also be aware of the limitations of the plan. This involves identifying the assumptions that underlie the plan and the risks that are associated with the plan. The researcher must also be aware of the need for flexibility. This involves being prepared to make changes to the plan if necessary.

The final step in the identification of a problem is to evaluate the results. This involves comparing the actual results with the expected results. If there are any differences, it is necessary to identify the causes and to take corrective action. This may involve making changes to the plan or to the resources available.

is apparently an over-representation of lower income persons in the Commission for the Blind registry growing out of the reluctance of some ophthalmologists to report middle and upper income patients. Thus mandatory reporting can be relied on only partially as a device for locating blind persons in the population. Means of identifying the "hidden" blind population resulting from non-compliance with the law, would seem to require the development of specialized research techniques.

The interviews with ophthalmologists reveal a pressing need for the development of a body of principles and practices in relation to rôle to which both they and rehabilitation experts can subscribe. Their responses also indicate the need for the development of materials interpreting how services can be adapted to meet the requirements of individuals of varying ages, income levels, health conditions and educational backgrounds.

RECOMMENDATIONS

Incorporated in the above conclusions are numerous recommendations relating to the need for further study of significant problem areas not covered by this exploratory pilot study; validation of the pilot study findings through further research; and the immediate use of those findings which would have value in relation to current agency policies and practices without further study or documentation.

The findings of the pilot study suggests that the most important of the needed research and demonstration programs fall into three broad categories:

- 1) strengthening the role of the ophthalmologist and other medical personnel in rehabilitation programming;
- 2) understanding and meeting individual needs of visually handicapped persons, and;
- 3) public education in relation to blindness.

Since it is not possible to give attention to all of the problem areas simultaneously it is recommended that priority be given to a research and demonstration study in which the role of the ophthalmologist and the timing of rehabilitation services are given priority. It is further recommended that the continuing study be: 1) conducted in several eye clinics in hospital centers; 2) include control groups of patients at the point when the diagnosis of irreversible blindness is initially made, and 3) involve the ophthalmologist, the medical social worker, the patient, the patient's family, the specialized agency and other personnel who may be concerned in the rehabilitation needs of the patient.

A detailed proposal for a research and demonstration grant will be prepared related to the objective of providing needed rehabilitation services to the visually handicapped as early as possible.

...the first of these is the...
...the second of these is the...
...the third of these is the...
...the fourth of these is the...
...the fifth of these is the...
...the sixth of these is the...
...the seventh of these is the...
...the eighth of these is the...
...the ninth of these is the...
...the tenth of these is the...

The first of these is the...
...the second of these is the...
...the third of these is the...
...the fourth of these is the...
...the fifth of these is the...
...the sixth of these is the...
...the seventh of these is the...
...the eighth of these is the...
...the ninth of these is the...
...the tenth of these is the...

DISCUSSION

In the first of these...
...the second of these...
...the third of these...
...the fourth of these...
...the fifth of these...
...the sixth of these...
...the seventh of these...
...the eighth of these...
...the ninth of these...
...the tenth of these...

The first of these...
...the second of these...
...the third of these...
...the fourth of these...
...the fifth of these...
...the sixth of these...
...the seventh of these...
...the eighth of these...
...the ninth of these...
...the tenth of these...

It is not possible to give...
...the second of these...
...the third of these...
...the fourth of these...
...the fifth of these...
...the sixth of these...
...the seventh of these...
...the eighth of these...
...the ninth of these...
...the tenth of these...

A detailed paper...
...the second of these...
...the third of these...
...the fourth of these...
...the fifth of these...
...the sixth of these...
...the seventh of these...
...the eighth of these...
...the ninth of these...
...the tenth of these...

TABLES

<u>Table #</u>		<u>Page</u>
1	Time Gap Between Development of Serious Eye Condition as Reported by Blind Respondents, and Offer of Specialized Services (Through the Referral System of The New York State Commission for the Blind)	12
2	Factors Which May Cause or Influence the Time Gap Between the Onset of Blindness and the Seeking of Specialized Rehabilitation Services	16
3	Respondent's Own Estimate of Sight (Legally Blind)	19
4	Families' and Friends' Estimate of Legally Blind Respondents' Sight (As Reported by Blind Respondents)	19
5	Reaction of Respondents to the Use of Word "Blind" in Relation to Themselves	19
6	Attitudes of Blind Respondents Toward Relationships with Other Blind Persons	21
7	Attitudes of Blind Respondents Toward the Separation of the Visually Handicapped from the Sighted (Segregated Activities)	22
8	Attitudes of Blind Respondents Toward Doing Things for Themselves	29
9	Attitudes of Family Members Toward Respondent Doing Things for Himself (As Expressed by Blind Respondents)	29
10	Principal Causes of Blindness as Classified by The New York State Commission for the Blind	32
11	Progression of Eye Condition as Reported by Blind Respondent	33
12	Comparison of Time Gap and Progression of Eye Condition	34
13	Blind Respondents' Evaluation of the Adequacy of Medical Information Given Them by Their Doctor(s) About Their Eye Condition(s)	38
14 (A)	Extent of Blind Respondents' Awareness of <u>Specialized Agencies for the Blind</u>	40
(B)	Extent of Blind Respondents' Awareness of <u>Specialized Agency Services</u>	40
15	<u>Extent of Interest</u> Expressed by Blind Respondent in Specialized Services	43

TABLES Cont.

<u>Table #</u>		<u>Page</u>
16	Attitudes of Blind Respondents Toward Specialized Agencies for the Blind	51
17	Attitudes of Blind Respondents Toward Experiences With Specialized Agencies for the Blind	54
18	General Feelings Expressed by Blind Respondents Toward the Doctor(s) Who Have Examined Their Eyes	64
19	General Attitudes of Blind Respondents Toward Adequacy of Eye Medical Care	64
20	Time Gap Between Onset of Blindness and Seeking of Medical Care, As Reported by Blind Respondents	65
21	Time Gap Between Development of Serious Eye Condition and the Seeking of Medical Care, As Reported by Blind Respondents	65
22	Opinion of Blind Respondents About the Desirability of Physicians Giving Rehabilitation Suggestions to the Visually Handicapped	66
23 (A)	Suggestions Made by Ophthalmologists or Other Physicians for Specialized Services in Relation to Blindness as Reported by Blind Respondents	70
(B)	Types of Suggestions Made	70
24	Practice Setting of Ophthalmologists and Physicians Interviewed	72

Page	Chapter
1	1. Introduction
2	2. The Role of the Teacher
3	3. The Role of the Student
4	4. The Role of the Parent
5	5. The Role of the Community
6	6. The Role of the Government
7	7. The Role of the Church
8	8. The Role of the Media
9	9. The Role of the Arts
10	10. The Role of the Sciences
11	11. The Role of the Humanities
12	12. The Role of the Social Sciences
13	13. The Role of the Natural Sciences
14	14. The Role of the Health Sciences
15	15. The Role of the Environmental Sciences
16	16. The Role of the Agricultural Sciences
17	17. The Role of the Biological Sciences
18	18. The Role of the Physical Sciences
19	19. The Role of the Earth Sciences
20	20. The Role of the Atmospheric Sciences
21	21. The Role of the Oceanographic Sciences
22	22. The Role of the Planetary Sciences
23	23. The Role of the Astronomical Sciences
24	24. The Role of the Space Sciences
25	25. The Role of the Interdisciplinary Sciences
26	26. The Role of the Transdisciplinary Sciences
27	27. The Role of the Converging Sciences
28	28. The Role of the Diverging Sciences
29	29. The Role of the Emerging Sciences
30	30. The Role of the Future Sciences

APPENDIX I

NAMES MADE AVAILABLE BY THE N.Y. STATE COMMISSION FOR THE BLIND

(629 PERSONS REGISTERED IN 1964-65 NOT KNOWN TO N.Y.C. SPECIALIZED AGENCIES FOR THE BLIND ACCORDING TO RECORD AVAILABLE IN THE COMMISSION)

I.	Number of persons advising the Commission No Service Desired and no referral was made.	97
II.	Number of names referred to Specialized Agencies for Screening (BB-82) - (IHB-148) - (JGB-151) - (NYA-151)*	$\frac{532}{629}$
III.	Case Status of 532 names as screened by Specialized Agency (November 1965)	
	A. Available for inclusion in Study Sample (470)	
	1. In Service Status	157
	2. Previous Service given by Specialized Agency	47
	3. Rejected Service when offered by agency	118
	4. No Response to agency offer of service	119
	5. Pending Reception Status in agency	29
		470
	B. Not Available for inclusion in Study Sample (62)	
	1. Deceased	18
	2. Moved Unavailable	33
	3. Inappropriate to Visit (illness etc.)	11
		62
IV.	Number of names available for interviews (567)	
	A. Number of names available after screening by Agency	470
	B. Number of No Service Desired names available for Study Sample	97
	TOTAL number of names available for use in the Study	567
V.	Number of names allotted to Agencies and Schools for Assignment to Interviewers (252)	
	<u>Service Cases - 97</u>	
	1. In Service Status	68
	2. Previous Service given by Agency	9
	3. Pending/Reception	20
		97

* BB - Brooklyn Bureau of Social Service
IHB - Industrial Home for the Blind

JGB - Jewish Guild for the Blind
NYA - New York Association for the Blind

APPENDIX I (Cont.)

No Service Received - 155

1. No Service Desired (no referral to agency)	61
2. Rejected Service offer by Specialized Agency	45
3. No Response to offer of service by Specialized Agency	49
	<u>155</u>

TOTAL number of cases allotted to agencies and schools for Assignment to Interviewers 252

VI. Case Status of 252 names as screened by Interviewers (2/15/66)

A. 1. Moved Unknown	25
2. Refused (no reason given -14) (Family refused - respondent uninformed of blindness - 3)	17
3. Physically or emotionally ill	16
4. Deceased	11
5. Could not be found at address given	6
6. Not convenient at the time	6
7. Too aged	5
8. Interviewer could not keep appointment	3
9. Language barrier	2
	<u>91</u>

B. Surplus of cases allotted to agencies after completion of interviews as of 2/15/66 85

TOTAL number of cases not available or unused for interviewing 176

VII. Number of available names not needed for allocation 315

VIII. Completed interviews (by interviewer's deadline 2/15/66)

Service Cases - 35

1. In Service Status	30
2. Previous Service given by agency	1
3. Pending/Reception	4
	<u>35</u>

No Service Received - 41

1. No Service Desired (no referral to agency)	22
2. Rejected Service offer by Specialized Agency	14
3. No Response to offer of service by Specialized Agency	5
	<u>41</u>

TOTAL number of completed interviews (by interviewer's deadline 2/15/66) 76

APPENDIX I (Cont.)

IX. Interviews omitted from the sample - 11		
Mentally retarded or incapacitated	6	
Referred to the Commission too far back	2	
Not legally blind	1	
Deaf Mute	1	
Interview conducted by phone	1	
	<u>11</u>	
TOTAL number of interviews omitted from the sample		11
X. COMPLETED BLIND RESPONDENT INTERVIEWS IN SAMPLE - 65		
<u>Service Cases - 30</u>		
1. In Service Status	25	
2. Previous Service given by agency	1	
3. Pending/Reception	4	
	<u>30</u>	
<u>No Service Received - 35</u>		
1. No Service Desired (no referral to agency)	20	
2. Rejected Service offer by Specialized Agency	11	
3. No Response to offer of service by Specialized agency	4	
	<u>35</u>	
TOTAL BLIND RESPONDENT INTERVIEWS IN SAMPLE		<u>65</u>
XI. Collateral Interviews - 19		
1. Ophthalmologists	9	
2. Other Physicians	4	
3. Relatives	5	
4. Friends	1	
	<u>19</u>	
TOTAL completed collateral interviews		19
XII. TOTAL INTERVIEWS COMPLETED AND INCLUDED IN STUDY		84

II. Laboratory with One Sample - 11

Method: selected or randomized
Interview to the candidate for the
the party also
Interview conducted by name

6-20-11

That number of interviews conducted for the party

I. Candidate with Multiple Interviews in Party - 12

Interview 1 - 12

1. In Party Interview
2. Interview conducted after the party
3. Interview conducted

6-20-11

Interview 2 - 12

1. In Party Interview (see above)
2. Interview conducted after the party
3. Interview conducted after the party

6-20-11

Total number of interviews conducted for the party

Collection Interview - 13

1. Interview conducted
2. Interview conducted
3. Interview conducted
4. Interview conducted

6-20-11

Total number of interviews conducted for the party

Total number of interviews conducted for the party

11

12

13

14

APPENDIX II

CHARACTERISTICS OF THE SAMPLE OF BLIND PERSONS INTERVIEWED

	<u>TOTAL</u> <u>Sample</u>		<u>No Service</u> <u>Received</u>		<u>Service</u> <u>Cases</u>	
	N-65	%-100*	N-35	%-100*	N-30	%-100*
<u>Geographic (Borough)</u>						
Manhattan	20	31	11	32	9	30
Brooklyn	20	31	13	37	7	24
Queens	11	17	7	20	4	13
Bronx	13	20	4	11	9	30
Staten Island	1	2	-	-	1	3
<u>Sex</u>						
Male	43	66	22	63	21	70
Female	22	34	13	37	9	30
<u>Marital Status</u>						
Married	40	62	22	63	18	60
Single	11	17	5	14	6	20
Divorced/Widowed	14	21	8	23	6	20
<u>Number of Children(living)</u>						
None	21	32	7	20	14	47
One	11	17	6	17	5	17
Two	16	24	11	31	5	17
Three - Four	14	21	9	26	5	17
Five - more	3	5	2	6	1	3
<u>Age</u>						
19	1	2	-	-	1	3
21-39	2	3	1	3	1	3
40-59	21	32	6	17	15	50
60-64	18	28	14	40	4	14
65-69	13	20	8	23	5	17
70 and over	10	15	6	17	4	13
<u>Birthplace</u>						
U.S.A.	42	64	25	70	17	57
Other Countries	20	31	10	30	10	33
No information	3	5	-	-	3	10
<u>Education</u>						
Some Grammar	21	32	15	42	6	20
Completed Grammar	14	21	9	26	5	16.5
Some High School	6	9	2	6	4	13
Completed High School	11	17	3	9	8	27
Some/Completed College	6	9	4	11	2	7
College +	6	9	1	3	5	16.5
Vocational/Technical	1	2	1	3	-	-
<u>Employment Status</u>						
No	60	92	32	91	28	93
Yes	5	8	3	9	2	7

* Due to rounding off of percentages, total columns will not always add to 100%

CHARACTERISTICS OF THE SAMPLE IN DIFFERENT CATEGORIES

Category	No. of persons		%	
	Male	Female	Male	Female
Geographic (Region)	Western	20	20	20
	Central	20	20	20
	Eastern	20	20	20
	South	20	20	20
	Other	20	20	20
Marital Status	Married	20	20	20
	Single	20	20	20
	Divorced	20	20	20
Number of Children (Living)	None	20	20	20
	One	20	20	20
	Two	20	20	20
	Three - Four	20	20	20
	Five - more	20	20	20
Age	17	20	20	20
	18-20	20	20	20
	21-25	20	20	20
	26-30	20	20	20
	31-35	20	20	20
	36-40	20	20	20
	41 and over	20	20	20
Education	Illiterate	20	20	20
	Some primary	20	20	20
	High school	20	20	20
Occupation	Unemployed	20	20	20
	Self-employed	20	20	20
	Government	20	20	20
	Private	20	20	20
	Professional/Technical	20	20	20
	College	20	20	20
	Other	20	20	20
Religious Beliefs	None	20	20	20
	Other	20	20	20

The percentages of persons in each category will not always add to 100% due to rounding.

APPENDIX II (Cont.)

	TOTAL Sample		No Service Received		Service Cases	
	N-65	%-100*	N-35	%-100*	N-30	%-100*
<u>Religion</u>						
Catholic	31	48	17	48	14	48
Jewish	17	26	10	29	7	23
Protestant	14	21	7	20	7	23
Other	2	3	1	3	1	3
No information**	1	2	-	-	1	3
<u>Race</u>						
White	51	78	31	89	20	67
Negro	14	22	4	11	10	33
<u>Household Income</u>						
0 - 2,000	22	35	16	45	6	20
2,001 - 3,000	9	14	3	9	6	20
3,001 - 5,000	12	18	7	20	5	17
5,001 - 7,500	6	9	3	9	3	10
7,501 - 10,000	2	3	1	3	1	3
Over - 10,000	4	6	2	6	2	7
No information**	10	15	3	9	7	23
<u>Personal Income</u>						
0 - 2,000	33	51	21	60	12	40
2,001 - 3,000	6	9	3	9	3	10
3,001 - 5,000	6	9	4	11	2	7
5,001 - 7,500	2	3	-	-	2	7
7,501 - 10,000	-	-	-	-	-	-
Over - 10,000	1	2	1	3	-	-
No information**	17	26	6	17	11	37
<u>Main Sources of Personal Income***</u>						
Own Salary, wages, com- missions	5	8	2	6	3	10
Savings	3	5	2	6	1	3
Stocks, bonds, real estate	5	8	3	9	2	7
Relatives - Spouse	7	11	2	6	5	17
Children	5	8	2	6	3	10
Public Assistance	11	17	6	17	5	17
Social Security	27	41	15	43	12	40
Disability Insurance	15	23	8	23	7	23
Parents	1	2	-	-	1	3
Pension****	12	18	10	29	2	7
Other	1	2	-	-	1	3
No information**	7	11	4	11	3	10

* Due to rounding off of percentages, total columns will not always add to 100%

** No Information: This category of non-response in all of the tables in this report indicates that no information was available to the research staff either because it was not given by the respondent or because it was not requested by the interviewer.

*** Multiple answers; will not add up to 100%

**** Includes union, Veterans Administration, municipal pensions, etc.

No. of persons		Total		No. of persons	
Male	Female	Male	Female	Male	Female
1	1	2	0	1	1
2	2	4	0	2	2
3	3	6	0	3	3
4	4	8	0	4	4
5	5	10	0	5	5
6	6	12	0	6	6
7	7	14	0	7	7
8	8	16	0	8	8
9	9	18	0	9	9
10	10	20	0	10	10
11	11	22	0	11	11
12	12	24	0	12	12
13	13	26	0	13	13
14	14	28	0	14	14
15	15	30	0	15	15
16	16	32	0	16	16
17	17	34	0	17	17
18	18	36	0	18	18
19	19	38	0	19	19
20	20	40	0	20	20
21	21	42	0	21	21
22	22	44	0	22	22
23	23	46	0	23	23
24	24	48	0	24	24
25	25	50	0	25	25
26	26	52	0	26	26
27	27	54	0	27	27
28	28	56	0	28	28
29	29	58	0	29	29
30	30	60	0	30	30
31	31	62	0	31	31
32	32	64	0	32	32
33	33	66	0	33	33
34	34	68	0	34	34
35	35	70	0	35	35
36	36	72	0	36	36
37	37	74	0	37	37
38	38	76	0	38	38
39	39	78	0	39	39
40	40	80	0	40	40
41	41	82	0	41	41
42	42	84	0	42	42
43	43	86	0	43	43
44	44	88	0	44	44
45	45	90	0	45	45
46	46	92	0	46	46
47	47	94	0	47	47
48	48	96	0	48	48
49	49	98	0	49	49
50	50	100	0	50	50

... of persons ... will not ...
 ... of persons ... will not ...
 ... of persons ... will not ...

APPENDIX II (Cont.)

	TOTAL Sample		No Service Received		Service Cases	
	N-65	%-100	N-35	%-100	N-30	%-100
<u>Residential Status</u>						
With Others	52	80	28	80	24	80
Alone	13	20	7	20	6	20
<u>How long in present living arrangement</u>						
Under 6 mos.	-	-	-	-	-	-
6 mos. - 1 yr.	5	8	3	9	2	7
More than 1 yr. less than 3 yrs.	8	12	3	9	5	17
More than 3 yrs. less than 5 yrs.	7	11	3	9	4	13
5 - 10 yrs.	10	15	4	11	6	20
11 - 15 yrs.	5	8	4	11	1	3
16 - 20 yrs.	2	3	1	3	1	3
Over 20 yrs.	20	31	14	39	6	20
No information	8	12	3	9	5	17
<u>No. of Persons living in Home</u>						
One	11	17	8	23	3	10
Two	23	35	13	36	10	33
More than 2/less than 5	16	24	9	26	7	23
5 - 7	4	6	2	6	2	7
8 - 10	-	-	-	-	-	-
11 - 15	-	-	-	-	-	-
More than 15 (institution, etc.)	1	2	1	3	-	-
No information	10	15	2	6	8	27

NEW YORK STATE DEPARTMENT OF SOCIAL WELFARE
COMMISSION FOR THE BLIND

15 PARK ROW, NEW YORK, N. Y. 10038
TEL. BARCLAY 7-1616

GEORGE K. WYMAN
COMMISSIONER



OSCAR FRIEDENSOHN
DIRECTOR

APPENDIX III

SAMPLE COPY

We have recently learned that you have seriously impaired vision. We feel sure it would be helpful for you to know about services available to visually handicapped persons in New York City. These services which include counseling and guidance, job training and placement, homemaking activities, travel techniques, braille instruction and talking book service are provided by local private agencies in cooperation with the Commission.

An agency offering some of these services is the _____ Unless you prefer that we not do so, we shall ask this agency to contact you to discuss its program. A pamphlet published by the agency is enclosed. If we do not hear from you by _____, we shall assume that you would like your name to be given to them.

We are also enclosing some brochures describing Commission services and a directory of other agencies for the blind in New York City. If you prefer to talk with an agency, other than the one mentioned above, we will gladly refer your name to the agency of your choice.

After careful consideration of the enclosed literature, please indicate your decision in the appropriate place provided below.

Sincerely,

Community Services Consultant
Ext.

Please refer my name to this agency _____

I am interested in the Commission's Vocational Rehabilitation Program.

I would like a Talking Book Machine.

I am not interested in any service at this time.

Encs.

Comm. 26 (Rev. 2 - 1/65)
ECP



ARTICLE III

CHAPTER ONE

The Board of Trustees of the State of New York, in and through the Commission for the Blind, do hereby certify that the following is a true and correct copy of the original of the same as the same appears in the files of the Commission for the Blind.

It is the policy of the State of New York to provide for the education, training and rehabilitation of the blind and visually handicapped persons in order that they may be able to support themselves and their families and to contribute to the welfare of the State.

The Commission for the Blind is authorized to receive and expend funds for the education, training and rehabilitation of the blind and visually handicapped persons in accordance with the provisions of the Education Law of the State of New York.

The Commission for the Blind is authorized to enter into contracts with other agencies for the education, training and rehabilitation of the blind and visually handicapped persons.

Witness my hand and the seal of the Commission for the Blind at Albany, New York, this _____ day of _____, 19____.

Commissioner for the Blind
Albany, New York

- I am not interested in any service of this kind.
- I am interested in the Commission's educational and training services.
- I am interested in the Commission's rehabilitation services.
- I am interested in the Commission's other services.

BIBLIOGRAPHY

- Allport, Gordon W., The Nature of Prejudice, Addison-Wesley Publishing Co., Inc., Cambridge, Mass., 1954.
- "An Analysis of the Principal Causes of Blindness in New York State During 1964", New York State Commission for the Blind, No date.
- Benedict, Ruth, Patterns of Culture, Riverside Press, Cambridge, Mass., 1934.
- "The Blind in Early Childhood and in Age", Proceedings of a Symposium of the Social Service Department, The N.Y. Guild for the Jewish Blind, New York, N.Y., 1954.
- Borgatta, Edgar F., David Fanshel and Henry J. Meyer, Social Workers' Perceptions of Clients, Russell Sage Foundation, New York, N.Y., 1960.
- Braley, A.E., M.D., "The Problems of the Definition of Blindness", from Proceedings of the Thirty-Sixth Convention of the American Association of Workers for the Blind, Inc., Washington, D.C., 1962.
- Carroll, Rev. Thomas J., Blindness, Little Brown & Co., Boston, Mass., 1961.
- Chevigny, Hector, My Eyes Have a Cold Nose, Yale University Press, New Haven, Conn., 1946.
- Cholden, L., M.D., A Psychiatrist Works With Blindness, American Foundation for the Blind, New York, N.Y., 1957.
- Cutsforth, Thomas D., The Blind in School and Society, American Foundation for the Blind, New York, N.Y., 1951.
- Fanshel, David, The New Partnership of Research and Practice, paper presented at Annual Workshop for Field Instructors and Faculty, Columbia University School of Social Work, New York, N.Y., 1965.
- Farrell, Gabriel, The Story of Blindness, Harvard University Press, Cambridge, Mass., 1956.
- Finestone, Samuel, The Demand for Guide Dogs, Research Center, The New York School of Social Work, Columbia University, New York, N.Y., 1960.
- Finestone, Samuel, ed. Social Casework and Blindness, American Foundation for the Blind, New York, N.Y., 1965.
- Finestone, Samuel, and Dr. Sonia Gold, The Role of the Ophthalmologist in the Rehabilitation of Blind Patients, American Foundation for the Blind, New York, N.Y., Morristown, N.J., 1959.
- Gans, Herbert J., The Urban Villagers, Free Press of Glencoe, New York, N.Y., 1963.
- Glazer, N., and Moynihan, P., Beyond the Melting Pot, M.I.T. Press, Cambridge, Mass., 1963.
- Goffman, Erving, Stigma, Prentice-Hall, Inc., Englewood Cliffs, New Jersey, 1963.

Alford, Gordon W., The History of Psychology, London: George Allen & Unwin, 1922.

An analysis of the principal causes of blindness in New York State during 1909. New York State Commission for the Blind, New York, 1910.

Bentley, John, Education of the Blind, London: George Allen & Unwin, 1911.

The blind in early childhood and later, including a description of a special type of blindness. The N. Y. State Commission for the Blind, New York, N. Y., 1911.

Burgess, John, Blindness in Childhood, London: George Allen & Unwin, 1911.

Casey, J. H., The Education of the Blind, London: George Allen & Unwin, 1911.

Casey, J. H., Blindness in Childhood, London: George Allen & Unwin, 1911.

Casey, J. H., Blindness in Childhood, London: George Allen & Unwin, 1911.

Casey, J. H., Blindness in Childhood, London: George Allen & Unwin, 1911.

Casey, J. H., Blindness in Childhood, London: George Allen & Unwin, 1911.

Casey, J. H., Blindness in Childhood, London: George Allen & Unwin, 1911.

Casey, J. H., Blindness in Childhood, London: George Allen & Unwin, 1911.

Casey, J. H., Blindness in Childhood, London: George Allen & Unwin, 1911.

Casey, J. H., Blindness in Childhood, London: George Allen & Unwin, 1911.

Casey, J. H., Blindness in Childhood, London: George Allen & Unwin, 1911.

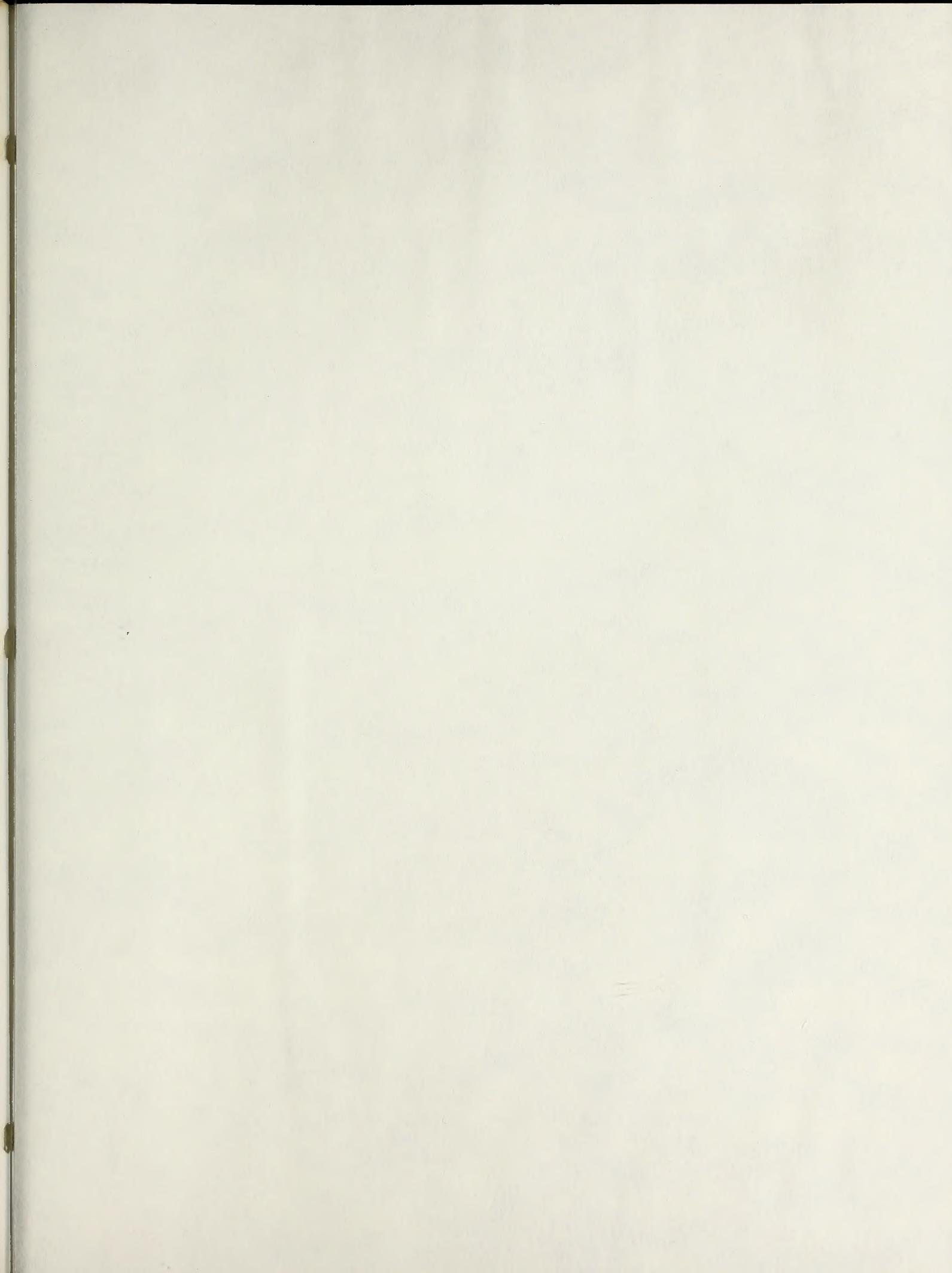
Casey, J. H., Blindness in Childhood, London: George Allen & Unwin, 1911.

Casey, J. H., Blindness in Childhood, London: George Allen & Unwin, 1911.

Casey, J. H., Blindness in Childhood, London: George Allen & Unwin, 1911.

BIBLIOGRAPHY (Cont.)

- Gowman, A.G., The War Blind in American Social Structure, American Foundation for the Blind, New York, N.Y., 1957.
- "Human Welfare in the Next Half Century", Jewish Guild for the Blind, 50th Anniversary, American Foundation for the Blind, New York, N.Y., 1964.
- Josephson, Eric, "A Pilot Study of Visual Impairment", American Foundation for the Blind, New York, N.Y., 1965.
- Lemert, Edwin M., Social Pathology, McGraw-Hill Inc., New York, N.Y., 1951.
- Merton, Robert K., Social Theory and Social Structure, The Free Press, Glencoe, Ill., 1949.
- Merton, Robert K., Leonard Broom, Leonard S. Cottrell, Jr., Sociology Today, Basic Books, Inc., New York, N.Y., 1959.
- Miller, Irving, Resistance to Cataract Surgery, American Foundation for the Blind, New York, N.Y., 1964.
- "The Ophthalmologist in Rehabilitation", an analysis of The Role of the Ophthalmologist in the Rehabilitation of Blind Patients, The Seeing Eye, Morristown, N.J., No date.
- Parsons, Talcott, "Illness and the Role of the Physician: A Sociological Perspective", in Kluckhohn, Clyde, Henry A. Murray, and David M. Schneider, Personality in Nature, Society and Culture, Alfred A. Knopf, New York, N.Y., 1953.
- "Providing Generalized Services for the Adult Blind", Research Proposal, Massachusetts Association for the Adult Blind, Boston, Mass., No date.
- Roehrer, G. Allan, "The Significance of Public Attitudes in the Rehabilitation of the Disabled", Rehabilitation Literature, National Society for Crippled Children and Adults, Vol. 22, No. 3, March, 1961.
- Saunders, L., Cultural Differences and Medical Care, Russell Sage Foundation, New York, N.Y., 1954.
- Shyne, Ann W., ed. "Use of Judgments as Data in Social Work Research", Conference Held by the Research Section of the National Association of Social Workers, National Association of Social Workers, New York, N.Y., 1959.
- Smithdas, Robert J., Life at My Fingertips, Doubleday & Co., New York, N.Y., 1958.
- Twersky, Jacob, "Blindness in Literature", American Foundation for the Blind, New York, N.Y., 1955.
- Zahl, Paul, ed. Blindness, Princeton University Press, Princeton, N.J., 1950.



THE UNIVERSITY OF CHICAGO
LIBRARY

1950

2

THE UNIVERSITY OF CHICAGO
LIBRARY

9/21/2012

T

272708 5 12 00



HF GROUP - IN

